Subscriber Agreement & Attachment Handbook
For Employees and Eligible Dependents of

State of Iowa

07MD

January 1, 2007
through

December 31, 2007

Enrolled in

UnitedHealthcare Plan of the River Valley, Inc.

WELCOME

Welcome to UnitedHealthcare Plan of the River Valley, Inc. The following Subscriber Agreement, with its attachments and amendments, explains your healthplan benefits. Please read this information carefully and keep it for future reference.

When your coverage became effective, you should have received your ID cards, which lists your coverage codes and any dependents covered under your plan. If there are any changes in your family status or address, or if you obtain other health benefit coverage, please notify your Personnel Office.

If you need a list of participating providers, or if you have any questions, please call Customer Service at the telephone number on your ID card.

Thank you for joining UnitedHealthcare Plan of the River Valley, Inc.

THIS CONTRACT
PROVIDES FOR COMPREHENSIVE
HEALTH CARE TO THE EXTENT HEREIN
LIMITED AND DEFINED

Issued By

UnitedHealthcare Plan of the River Valley, Inc.

A Corporation Certified Under the Applicable Laws
of the State of Operation

SUBSCRIBER AGREEMENT
UNDER GROUP HEALTH CONTRACT

This Contract is between the Subscriber who has executed an application for enrollment and UnitedHealthcare Plan of the River Valley, Inc. ("UnitedHealthcare").

This Contract entitles the Subscriber and Eligible Dependents to receive the benefits set forth herein for the Contract Period, subject to the terms and conditions of this Contract and upon payment of the Premium.

UnitedHealthcare Plan of the River Valley, Inc.

By:_____

President

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ARTICLE I - DEFINITIONS

1.1 **Allowed Charge** - the portion of a charge for a service or supply that UnitedHealthcare will consider in calculating benefits. The Allowed Charge is determined as follows:

1.1.1 For services received from a Participating Provider, the Allowed Charge is the rate UnitedHealthcare has agreed to pay the Participating Provider under a contract.

1.1.2 For services received from a Non-Participating Physician due to a Medical Emergency or with a Preauthorized Referral, the Allowed Charge is the Reasonable and Customary charge. Enrollee is not responsible for the difference between the Non-Participating Physician's billed charge and the Reasonable and Customary Charge. If the Non-Participating Provider bills the Enrollee for this difference, the Enrollee should contact UnitedHealthcare. For services received from a Non-Participating Provider which is a hospital or a facility, due to a Medical Emergency or with a Preauthorized Referral, the Allowed Charge is the Non-Participating Provider's billed charge.

1.2 **Appeal** – a complaint, which having been reported to UnitedHealthcare by the Enrollee and remaining unresolved to the Enrollee's satisfaction, is filed for formal proceedings as set forth in Article XVIII.

1.3 **Attending Physician** - a Participating Physician who is primarily responsible for the care of an Enrollee with respect to any particular injury or illness.

1.4 **Coinsurance** – a percentage of the Allowed Charge that the Enrollee must pay for services received. The percentage is described in Attachment D.

1.5 **Contract** - this agreement, any endorsements hereon and attached papers, if any, and the Subscriber's application constitute the entire Contract between UnitedHealthcare and the Subscriber.

1.6 **Contract Period** – refer to Attachment A.

1.7 **Copayment** – the amount, if any, the Enrollee must pay for each medical service received, such as a doctor office visit. The amount is specified per service, and is shown in Attachment D. Each Copayment shall be paid at the time the service is provided.

1.8 **Deductible** – the amount, if any, the Enrollee must pay for health services, before UnitedHealthcare begins to pay. The amount is shown in Attachment D. Only those charges which would otherwise be payable by UnitedHealthcare in the absence of application of the Deductible shall count toward the Deductible. Any charges in excess of Reasonable and Customary, whether or not paid by the Enrollee, will not apply toward any applicable Deductible shown in Attachment D. Furthermore, if any supplemental benefits are attached to this Contract, such as but not limited to prescription drug, dental, vision, or hearing, amounts paid by the Enrollee in connection with any of those supplemental benefits will not apply toward any applicable Deductible shown in Attachment D.

1.9 **Eligible Dependent** - a person who meets UnitedHealthcare's eligibility requirements set forth in Attachment B.

1.10 **Enrollee** - the Subscriber and any Eligible Dependents who are enrolled in UnitedHealthcare.

1.11 **Group** - the sole proprietor, partnership, association or corporation, including any and all successors, through which the Enrollee has enrolled, and which has agreed to collect and remit the Premiums payable under this Contract.

1.12 **Home Health Services** – care when an Enrollee is confined to his or her home related to a recuperative or treatable illness or injury, is approved in advance by UnitedHealthcare, and is provided by a Home Health Agency.

1.13 **Home Health Agency** - a public or private agency that specializes in providing nursing services in the home; is duly licensed to operate as a Home Health Agency under applicable state or local laws; and has a contractual relationship with UnitedHealthcare.

1.14 **Hospital Service** - bed and board of the character classed as semiprivate or intensive care and all other services customarily furnished in a Participating Hospital or Nursing Facility.

1.15 **Lifetime Maximum** - the if a Lifetime Maximum is specified in Attachment D, this amount represents the maximum dollar amount of benefits for each Enrollee payable by UnitedHealthcare. The Lifetime Maximum is reached when the total of claims paid by UnitedHealthcare under all UnitedHealthcare Subscriber Agreements, however named, covering Enrollee through Group equals the Lifetime Maximum amount. All benefits paid by UnitedHealthcare for Enrollee will be included in determining when Enrollee's Lifetime Maximum is met, including but not limited to claims paid under any supplemental benefits rider, claims accumulated toward any specific benefit maximum shown in Attachment D, and claims paid by UnitedHealthcare to Participating Providers under any capitation arrangement. When UnitedHealthcare has paid claim amounts equal to or exceeding the Lifetime Maximum, UnitedHealthcare will have no liability under this Contract for further benefits for that Enrollee and shall have the right to recover amounts paid in excess of the Lifetime Maximum.

1.16 **Maximum Out of Pocket Expense**– the sum total amount of Copayments, Coinsurance, and Deductibles, as shown for an individual or family in Attachment D and paid by an Enrollee, after which – for the remainder of the calendar year – UnitedHealthcare will pay 100% of the Allowed Charge for that Enrollee's subsequent health care services covered by this Contract. However, amounts in excess of Reasonable and Customary will not apply toward any applicable Maximum Out of Pocket Expense shown in Attachment D. Also, if any supplementary benefits are attached to this Contract, such as but not limited to prescription drug, dental, vision, or hearing, amounts paid by the Enrollee in connection with any of those supplementary benefits will not apply toward any applicable Maximum Out of Pocket Expense shown in Attachment D.

1.17 **Medical Emergency** – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1.17.1 placing the health of the individual (or with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy; or

1.17.2 serious impairment of bodily functions; or

1.17.3 serious dysfunction of any bodily organ or part.

1.18 **Medicare Act** - Title XVIII of the Social Security Act, as amended from time to time.

1.19 **Non-Participating Physician** – any physician who has not entered into a direct or group contractual arrangement with UnitedHealthcare, or has not contracted with an intermediary entity that is contracted with UnitedHealthcare, for provision of health care services to Enrollees.

1.20 **Non-Participating Provider** - any provider, including but not limited to a physician, hospital or extended care facility, that has not entered into a network provider agreement with UnitedHealthcare or that has not contracted with an intermediary entity that is contracted with UnitedHealthcare.

1.21 **Nursing Facility** - an extended care facility which either (1) has a contractual relationship with UnitedHealthcare and is accredited as a Nursing Facility under applicable state law or (2) is recognized and eligible for payment under the Medicare Act.

1.22 **Participating Hospital** - an acute care general hospital that has entered into a network hospital agreement with UnitedHealthcare for the provision of Hospital Services to Enrollees.

1.23 **Participating Physician** - a Primary Care Physician. This term also includes any other duly licensed physician who has been designated by UnitedHealthcare as a Participating Physician and who has entered into either a direct or group Participating Physician agreement with UnitedHealthcare, for the provision of health care services to Enrollees. UnitedHealthcare will designate the services that Enrollees may receive from such physicians without a Preauthorized Referral.

1.24 **Participating Provider** - any provider, including but not limited to a physician, hospital or extended care facility, that has entered into a Participating Provider agreement with UnitedHealthcare, or that has contracted with an intermediary entity that is contracted with UnitedHealthcare, for the provision of health care services to Enrollees.

1.25 **Placed** or **Placement for Adoption –** the assumption and retention of a legal obligation for the total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligation.

1.26 **Preauthorized Referral** - written authorization provided by a Primary Care Physician for medically necessary covered services from 1) a Participating Provider other than a Primary Care Physician; or, 2) a Non-Participating Provider. Payment will be made only if the referral is obtained from a Primary Care Physician and approved by UnitedHealthcare prior to the time services are provided, except in the event of a Medical Emergency.

1.27 **Premium** - the periodic amount of money currently charged by UnitedHealthcare for benefits and services provided under this Contract.

1.28 **Primary Care Physician** - a Participating Primary Care Physician who has been identified in writing by UnitedHealthcare as a Primary Care Physician and who is:

1.28.1 A physician licensed to practice medicine, who spends a majority of clinical time engaged in general practice of internal medicine, pediatrics, gynecology, obstetrics or family practice, or

1.28.2 A licensed chiropractic physician.

1.29 **Reasonable and Customary** – the portion of any charge that is within the range charged for similar services and supplies in the area where the charge is made. Reasonable and Customary is determined by using data from the Health Insurance Association of America (HIAA), which collects fee information based on zip codes from insurance companies covering more than 95 million individuals. Reimbursement is based on the 80th percentile of HIAA profiles. Any amount paid by an Enrollee which is in excess of Reasonable and Customary for particular services or supplies shall not apply toward any applicable Deductible or Maximum Out of Pocket Expense shown in Attachment D.

1.30 **Service Area** - the geographical area set forth in Attachment C.

1.31 **Subscriber** - an individual who is eligible to participate in the health benefit plan offered by Group under this Contract and who has enrolled under this Contract.

ARTICLE II – ELIGIBILITY DATE/EFFECTIVE DATE

2.1 The eligibility date shall be the date on which an Enrollee is first deemed eligible by UnitedHealthcare to participate under this Contract.

2.1.1 If the Enrollee is the Subscriber, eligibility shall be determined as set forth in Attachment B.

2.1.2 If the Enrollee is a dependent, eligibility shall be determined as set forth in Attachment B.

2.2 The coverage effective date shall be the date on which an Enrollee is first deemed eligible by UnitedHealthcare to receive benefits under this Contract.

2.2.1 Benefits shall be provided when the Enrollee receives services on or after the coverage effective date.

2.2.2 Upon the acquisition of an Eligible Dependent, the Subscriber shall make written notification to the Group within 31 days of such change and the coverage effective date will be the acquisition date of the Eligible Dependent. If written notification of the acquisition of an Eligible Dependent is made to the Group more than 31 days after such coverage change, the coverage effective date for such change will not be more than 31 days prior to the date the Group received proper notification.

2.3 **Changes in Eligibility Status.** Subscriber shall provide Group written notification of any dependent status change within 31 days of such change. The Subscriber's failure to notify Group of an Enrollee's loss of Eligible Dependent status (for example, due to change in student status) shall not extend any person's coverage beyond the last day on which he or she qualifies as an Eligible Dependent. *Adding Eligible Dependents*: See *Special Enrollment*, section 2.4 of this Article II. *Canceling Coverage for Eligible Dependents*: When the Subscriber discontinues coverage for one or more Eligible Dependents, if notification of such change is received more than 31 days after the desired date of coverage change, the implemented date of the change will not be more than 31 days prior to the date Group received proper notification to remove the Eligible Dependent(s) from coverage.

2.4 **Special Enrollment**. UnitedHealthcare shall provide a special enrollment period during which an eligible individual may enroll for coverage under this Contract under certain conditions. For purposes of this section, the term "special enrollment period" means a period of 31 days during which an eligible employee is allowed to enroll himself or herself and/or any Eligible Dependents upon the occurrence of certain events and conditions as described below in sections 2.4.1 and 2.4.2.

2.4.1 *Prior coverage terminated or exhausted.* A special enrollment period is available due to loss of group or other health insurance coverage as described below:

2.4.1.1 *Coverage loss which creates special enrollment opportunity*. Special enrollment is available to persons specified in section 2.4.1.2 when:

2.4.1.1.1 COBRA continuation coverage with a prior carrier is exhausted; *or*

2.4.1.1.2 Coverage under another group health plan or other health insurance coverage, which is not under COBRA continuation coverage, has terminated as a result of: (1) loss of eligibility through legal separation, divorce, death, termination of employment or reduction in the number of hours worked; or (2) cessation of employer contributions.

2.4.1.2 *Persons who may be entitled to special enrollment due to loss of prior coverage.* A special enrollment period will be allowed for the persons described below

when a loss of coverage described in section 2.4.1.1 has occurred, and if enrollment takes place during the special enrollment period:

2.4.1.2.1 *For an eligible employee*, upon losing coverage under another plan.

2.4.1.2.2 *For an Eligible Dependent*, upon losing coverage under another plan, but only if such individual is an Eligible Dependent of an employee who is already covered under this Contract.

2.4.1.2.3 *For both the eligible employee and the employee's Eligible Dependent*, if either loses coverage under another plan.

2.4.1.3 In order to enroll due to loss of coverage as described above, the following conditions must be met:

2.4.1.3.1 The individual must be eligible to enroll under this Contract; and

2.4.1.3.2 The individual declined coverage under this Contract when the person first became eligible; and

2.4.1.3.3 When the individual declined such coverage, the individual was covered under another group's health plan or other health coverage; and

2.4.1.3.4 The employee stated in writing to UnitedHealthcare (if UnitedHealthcare required such a statement) that the existence of other coverage was the reason for declining enrollment for the employee and/or Eligible Dependent.

2.4.1.4 *Special Enrollment Period for Section 2.4.1.* To enroll due to loss of coverage, the employee must apply for coverage for the employee and/or Eligible Dependent within 31 days of loss of coverage.

2.4.2 *Acquisition of a Dependent.* A special enrollment period will be allowed for the persons described below when the described events occur, and if they enroll during the special enrollment period stated in section 2.4.2.6.

2.4.2.1 *For an employee who is eligible but not enrolled*: when he/she marries or has a child as the result of marriage, birth, adoption, interim court order for adoption or legal guardianship, or Placement for Adoption;

2.4.2.2 *For an individual who becomes a spouse of a Subscriber*: at the time of marriage, or when a child becomes an Eligible Dependent of that Subscriber as the result of birth, adoption, interim court order for adoption or legal guardianship, or Placement for Adoption;

2.4.2.3 *For both an employee who is eligible but not enrolled and an eligible spouse*: when they marry or when a child becomes an Eligible Dependent of that Subscriber as the result of birth, adoption, interim court order for adoption or legal guardianship, or Placement for Adoption;

2.4.2.4 *For a child*: upon becoming an Eligible Dependent of a Subscriber as the result of marriage, birth, adoption, interim court order for adoption or legal guardianship, or Placement for Adoption;

2.4.2.5 *For both an employee who is eligible but not enrolled and a child*: when the child becomes an Eligible Dependent of the employee as the result of marriage, birth, adoption, interim court order for adoption or legal guardianship, or Placement for Adoption;

2.4.2.6 *Special enrollment period for section 2.4.2*. The employee must apply for coverage for the employee and/or Eligible Dependent within 31 days from the date of marriage, birth, adoption, interim court order for adoption or legal guardianship, or Placement for Adoption.

2.4.3 *Effective date of Enrollment*. For those enrolled during a special enrollment period, enrollment is effective as follows:

2.4.3.1 *Loss of Coverage*. In the case of prior coverage being terminated or exhausted, not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

2.4.3.2 *Marriage*. In the case of marriage, not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

2.4.3.3 *Birth*. In the case of an Eligible Dependent's birth, on the date of such birth.

2.4.3.4 *Adoption, Interim Court Order for Adoption or Legal Guardianship, or Placement for Adoption*. In the case of an Eligible Dependent's adoption, interim court order for adoption or legal guardianship, or Placement for Adoption, on the date of such adoption, interim court order for adoption or legal guardianship, or Placement for Adoption.

2.4.4 For purposes of counting creditable coverage, the enrollment date for anyone who enrolls under a special enrollment period is the first day of coverage. That is, the time between the date an individual becomes eligible for enrollment under this Contract and the first day of coverage is not treated as a waiting period.

ARTICLE III – SCHEDULE OF BENEFITS

3.1 Benefits listed in this Subscriber Agreement will be paid only when the services are provided by a Primary Care Physician or arranged or approved by a Primary Care Physician with a Participating Provider, except in the case of a Medical Emergency or Preauthorized Referral. All services whether directly provided or authorized by a Primary Care Physician will be subject to evaluation by UnitedHealthcare. Payment will not be made for any service provided to an Enrollee unless such service is listed and described in Attachment D.

3.2 **Medically Necessary.** Benefits will be paid only for a service or treatment, hospital, medical or otherwise, which is medically necessary. To be medically necessary the service or treatment must meet the following criteria as determined by the UnitedHealthcare and, if required by UnitedHealthcare, must be authorized on a prospective and timely basis by UnitedHealthcare:

3.2.1 The service or treatment is consistent with generally accepted principles of medical practice for the diagnosis and treatment of the Enrollee's medical condition; and,

3.2.2 The service or treatment is performed in the most cost-effective manner in terms of treatment, method, setting, frequency and intensity, taking into consideration the Enrollee's medical condition.

3.3 **Medical Management Processes.** UnitedHealthcare utilizes the following medical management processes:

3.3.1 **Preauthorization.** Some procedures, including certain medical and diagnostic procedures, require approval by UnitedHealthcare prior to the time those services are furnished ("preauthorization"). Established criteria are used to determine the appropriateness of those services and the level of care to be provided. If an Enrollee has any question as to whether or not a specific procedure requires preauthorization, he or she should call UnitedHealthcare at the toll-free number listed in Attachment E. Failure to obtain preauthorization will result in the Enrollee being responsible for the costs of the procedure and any associated expenses. Such costs and associated expenses will not be applied to any applicable Deductible or Maximum Out of Pocket Expense limits.

3.3.2 **Hospital or Nursing Facility Admission Notification.** If an Enrollee is admitted to a facility in the HMO network, that facility or the Participating Physician will notify UnitedHealthcare of the admission.

3.3.3 **Hospital or Nursing Facility Continued Stay Review.** Continued stay at a facility may be reviewed for appropriateness of care and services. This review will be performed by UnitedHealthcare. If a continued stay is determined by UnitedHealthcare to be no longer medically necessary, UnitedHealthcare may contact the Primary Care Physician to determine the need for the continued stay and request a plan of treatment. Any charges for services provided following the determination by UnitedHealthcare that services are not medically necessary will not be paid and will not be applied to any applicable Deductible or Maximum Out of Pocket Expense limits.

3.3.4 **Case Management.** UnitedHealthcare may engage in the medical management of certain treatment of Enrollees from time to time to help assure that appropriate health care is being provided to the Enrollee. This medical management may also coordinate various aspects of care provided to seriously ill or injured Enrollees.

ARTICLE IV - HOSPITAL SERVICES AND NURSING FACILITIES

4.1 Hospital Services shall be covered, subject to the limitations in Attachment D, only when an Enrollee is admitted to a Participating Hospital or Nursing Facility by a Primary Care Physician, except in the event of a Medical Emergency or with a Preauthorized Referral.

4.2 Hospital Services for psychiatric care and substance abuse including alcoholism are subject to the limitations of Articles III, VII and Attachment D.

4.3 Hospital Service charges in a Participating Hospital or Nursing Facility:

4.3.1 In semiprivate accommodations an Enrollee shall be entitled to Hospital Services and Participating Hospital or Nursing Facility shall not make any charge to the Enrollee except for any applicable Copayments, Coinsurance and Deductibles.

4.3.2 In private accommodations, an Enrollee shall be entitled to Hospital Service but in addition to the applicable Copayments, Coinsurance and Deductibles, the Enrollee shall pay directly to the Participating Hospital or Nursing Facility its regular charge for the private room occupied less credit equal to its most common charge for semiprivate accommodations. However, if private accommodations are authorized as medically necessary by a Primary Care Physician and/or UnitedHealthcare, the Enrollee shall be entitled to full coverage less any applicable Copayments, Coinsurance and Deductibles.

4.3.3 In an intensive care unit, an Enrollee shall be entitled to all services of the intensive care unit, including special duty nursing, and the Participating Hospital shall not make any charges to the Enrollee except for any applicable Copayments, Coinsurance and Deductibles.

ARTICLE V - SPECIAL BENEFITS

5.1 Professional care or other services under this Contract shall be covered, subject to the limitations in Attachment D, only when provided by a Primary Care Physician or arranged or approved by a Primary Care Physician with a Participating Provider, except in a Medical Emergency or with a Preauthorized Referral.

5.1.1 **Home Health Services** - An Enrollee confined to his or her home may be entitled to nursing services provided by a Home Health Agency. Such visits shall include part-time or intermittent home health care by or under the supervision of a registered nurse. Home Health Services may be ordered by either a Participating or Non-Participating Physician and must be approved in advance by UnitedHealthcare.

5.1.2 **Ambulance Service**

5.1.2.1 For emergencies, ambulance services will be covered to the nearest facility that is equipped and staffed to provide necessary services.

5.1.2.2 For non-emergencies, when medically necessary and when ordered by a Participating Provider, an Enrollee shall be entitled to coverage for ambulance services to a hospital, between hospitals when needed specialized care cannot be obtained at the first hospital, and between a hospital and a Nursing Facility.

5.1.3 **Outpatient Rehabilitative Therapy.** Outpatient rehabilitative therapy benefits will be paid for conditions resulting from disease or injury or when prescribed immediately following surgery related to the condition. Outpatient rehabilitative therapy includes physical, occupational, and speech therapy. Therapy must be ordered by a Physician and performed by a licensed therapist acting within the scope of his or her licensure.

Note: Occupational therapy shall not include vocational therapy, vocational rehabilitation, educational, or recreational therapy. UnitedHealthcare will cover occupational therapy performed by an occupational therapist to the extent that such therapy is performed to regain use of the upper extremities.

Note: Speech therapy will be covered only for a residual speech impairment resulting from a stroke, accidental injury or surgery to the head or neck.

5.1.4 **Prosthetic Devices** - Coverage for prosthetic devices includes:

a) Initial placement of a prosthetic device and its supportive device;

b) Maintenance and repair required for the successful use of the device;

c) Replacement of a device when required by growth or change in medical condition;

d) Replacement of a device due either to wear and tear or to technological improvement and determined by UnitedHealthcare to be medically necessary.

Prosthetic devices must be prescribed or arranged by a Participating Physician and must be supplied or repaired by a Participating Provider.

5.1.4.1 "Prosthetic devices" means those devices which replace all or part of a body organ (including contiguous tissue) or a diseased, malformed, or injured portion of the body or replace all or part of the function of a permanently inoperative or malfunctioning bodily organ or portion of the body.

5.1.5 **Durable Medical Equipment** - Benefits are payable for durable medical equipment supplied by a Participating Provider when prescribed or arranged by a Primary Care Physician for use in other than a hospital or facility that provides nursing or rehabilitation services. Benefits will not be paid for special features or equipment requested by the Enrollee for personal comfort or convenience unless medically necessary.

5.1.5.1 "Durable medical equipment" means medical equipment that (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) is not useful in the absence of illness or injury, and (4) is appropriate for home medical treatment.

5.1.5.2 In some cases, UnitedHealthcare may determine that purchase of the equipment is more appropriate than rental.

5.1.6 **Organ/Tissue Transplants.** Organ and tissue transplant services described in section 5.1.6.1 must be: a) ordered by a Primary Care Physician or a Participating Provider to whom the Primary Care Physician has authorized a referral of the Enrollee, b) approved in advance by UnitedHealthcare, and c) received from transplant centers approved by UnitedHealthcare; otherwise, benefits will not be paid. However, cornea transplants may be ordered by and performed by a Participating Provider that is not a UnitedHealthcare approved transplant center.

5.1.6.1 Benefits for all other organ and tissue transplant services will be payable as shown in Attachment D. This restriction applies to all services performed in conjunction with the transplant. Transplant services for an Enrollee who is a recipient of an organ or tissue transplant include all professional, technical and facility charges (inpatient and outpatient) for evaluation of the transplant procedure and follow-up care (12 months). If the recipient is an Enrollee, medically necessary professional, technical and facility charges for removal of the donated organ or tissue, as well as any direct complication resulting from the donation, are also covered by UnitedHealthcare for a live primary donor up to 90 calendar days after the date of the donation, unless such donation is covered by other insurance. Organ and tissues covered for transplant include: heart, heart/lung, kidney, kidney/pancreas, liver, lung, bone marrow and stem cell.

5.1.6.2 The Enrollee's Primary Care Physician, or a Participating Provider to whom the Primary Care Physician has authorized a referral of the Enrollee, must contact UnitedHealthcare for coordination of a referral to a transplant center approved by UnitedHealthcare prior to the time services are rendered, except for cornea transplants as described in section 5.1.6.

5.1.6.3 If an Enrollee is registered at two or more transplant centers for the same transplant (i.e. "multiple listing"), UnitedHealthcare will pay for covered services associated with only one approved transplant center waiting list. UnitedHealthcare will not pay for any charges related to additional transplant center waiting lists.

5.1.7 **Temporomandibular Joint Syndrome.** Treatment of temporomandibular or craniomandibular joint syndrome or disorders (hereafter "TMJ syndrome") is limited to services which are medically necessary in connection with fractures, neoplasms, rheumatoid arthritis, ankylosing spondylitis, disseminated lupus erythematosus, and acute dislocation of the mandible (but not dislocation of the

cartilage without dislocation of the mandible) from direct and extrinsic trauma. All services for TMJ syndrome must be ordered by a Primary Care Physician and provided by a Participating Provider or with a Preauthorized Referral. Osteotomy is not a covered treatment for TMJ syndrome.

5.1.8 Benefits are payable for general anesthesia and hospital or ambulatory surgical center charges provided:

5.1.8.1 To any Enrollee who, upon determination by a licensed dentist and the Attending Physician, has one or more medical conditions that would create significant or undue medical risk if necessary dental treatment or surgery were not rendered in a hospital or ambulatory surgical center; or

5.1.8.2 To an Enrollee who is a child under age five and who, upon determination by a licensed dentist and the child's Attending Physician, requires dental treatment in a hospital or ambulatory surgical center due to a dental condition or developmental disability for which patient management in the dental office has proven to be ineffective.

As used in Section 5.1.8.2, the term "developmental disability" refers to a mental or physical incapacity which usually manifests itself in infancy or childhood and is permanent, such as, but not limited to, cerebral palsy. The term does not include conditions such as, but not limited to, attention deficit disorder or attention deficit hyperactivity disorder.

5.1.9 **Exception for Certain Clinical Trials for Treatment Studies on Cancer, approved by National Cancer Institute (NCI) or National Institutes of Health (NIH**). Coverage is provided for "patient costs," as defined below, incurred by Enrollee during participation in a phase III clinical trial for treatment studies on cancer, including ovarian cancer trials, but only when ALL of the following conditions are met:

1. There is no clearly superior, non-investigational treatment alternative; and

2. The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative; and

3. The Enrollee and Enrollee's Participating Physician conclude that the Enrollee's participation in the clinical trial would be appropriate; and

4. A Preauthorized Referral is obtained in advance from UnitedHealthcare; and

5. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise; and

6. The treatment is provided by a clinical trial approved by one of the following: a) the NCI or b) an NCI "cooperative group" or an NCI center or the federal Department of Veterans Affairs. "Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NCI-approved peer review program operating within the group. "Cooperative group" includes the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program.

Coverage of "patient costs" incurred during participation in a clinical trial shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures.

"Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to Enrollee for purposes of a clinical trial. "Patient cost" does not include: a) the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial; b) costs associated with managing the research associated with the clinical trial; c) the cost of the investigational procedure, drug, pharmaceutical, device, or clinical trial therapies, regimens, or combinations thereof; d) costs associated with the provision of any goods, services, or benefits that are generally furnished without charge in connection with an approved clinical trial program for treatment of cancer; e) additional costs associated with the provision of any goods, services, or benefits that previously have been provided to, paid for, or reimbursed, or any similar costs; or f) treatments or services prescribed for the convenience of the Enrollee or his/her Attending Physician.

5.1.10 **Diabetes Self-Management.** Benefits are provided for equipment and supplies (blood glucose monitors and supplies including those for the legally blind), regular foot care examinations, and outpatient self-management training and education, including medical nutritional therapy, for treatment of insulin-dependent, insulin-using, gestational, and non-insulin using diabetes. Outpatient self-management training and education must be provided in person by a certified, registered, or licensed health care professional which is part of a UnitedHealthcare-approved diabetes education program.

ARTICLE VI - BENEFITS PROVIDED FOR MEDICAL CARE

6.1 Medical care under this Contract shall be covered, subject to the limitations in Attachment D, only when such care is provided by a Primary Care Physician or arranged or approved by a Primary Care Physician with a Participating Provider, except in a Medical Emergency or with a Preauthorized Referral.

6.1.1 Preventive care examinations (well-adult and well-child care) and associated services, including but not limited to immunizations to prevent or arrest the further manifestation of human illness or injury, laboratory testing or screening, and x-rays. "Preventive care" refers to services recommended by the U.S. Preventive Services Task Force or preventive care services mandated by state or federal law or regulation.

6.1.2 Medical eye exams (excluding refractions).

6.1.3 Casts and dressings.

6.1.4 Injections which are not usually self-administered.

6.1.5 Surgical care and associated anesthesia.

6.1.6 Health education services and wellness programs approved by UnitedHealthcare.

6.1.7 X-ray and laboratory tests and services, including pathology services and radiation therapy, for the treatment of illness or injury.

6.1.8 Blood transfusion services.

6.1.9 Consultations as needed between providers. When such consultation is by a Non-Participating Provider, the consultation must be approved by UnitedHealthcare prior to the time the services are provided, except in the event of a Medical Emergency.

6.1.10 Visits by a Primary Care Physician to an Enrollee at his or her home or in a Nursing Facility.

6.1.11 All covered medical supplies furnished in connection with the services provided above.

6.1.12 Reconstructive surgical procedures which are medically necessary to repair a functional disorder as a result of disease, injury or congenital anomaly. Benefits are also provided for: all stages of reconstructive breast surgery as a result of a mastectomy; reconstructive surgery on the other breast necessary to re-establish symmetry between the two breasts; prostheses; and treatment of physical complications, including medically necessary treatment of lymphedemas, at all stages of the mastectomy.

6.1.13 **Emergency Services.** Whenever possible, an Enrollee must contact his or her Primary Care Physician prior to receiving treatment for a Medical Emergency. If the Primary Care Physician is not immediately available, the Enrollee should seek emergency care at the most convenient health care facility.

6.1.13.1 **Emergency Services Within the Service Area.** When a Medical Emergency occurs in the Service Area (as defined in Attachment C), the Enrollee should seek medical attention immediately from a hospital, physician's office or other emergency facility. The use of a Participating Provider is encouraged when convenient and does not impede the health and well-being of the Enrollee.

6.1.13.2 **Emergency Services Outside the Service Area.** When the Enrollee is outside the Service Area, and a Medical Emergency occurs, the Enrollee should seek care immediately from a hospital, physician's office or other emergency facility. If is determined that a Medical Emergency existed and the visit to the hospital or emergency facility was medically necessary, the initial visit will be covered. Follow up visits must be arranged through the Enrollee's Primary Care Physician.

6.1.13.3 **Determination of Covered Benefits.** The determination of covered benefits for services rendered in a hospital or emergency facility is based on UnitedHealthcare's review of the Enrollee's emergency room medical records, along with those relevant symptoms and circumstances that preceded the provision of care. If it is determined that a Medical Emergency did not exist, or that services were not medically necessary, the Enrollee will be held financially responsible for those services. As a general rule, for UnitedHealthcare to determine that a Medical Emergency existed or that services were medically necessary, the date of the onset of symptoms and the date of treatment as reported on the claim form should be the same but not more than 24 hours after an illness or injury.

6.1.13.4 **Notification After Services are Received.** If due to the severity of his or her condition, the Enrollee was unable to notify his or her Primary Care Physician prior to seeking emergency care, the Enrollee should notify his or her Primary Care Physician within 48 hours after treatment is rendered, or as soon as reasonably possible. If the Enrollee is unable to notify due to his or her condition, or if the patient is a minor, this 48-hour period will be reasonably extended until the Enrollee or a responsible adult is able to notify.

6.1.14 Maternity care, including prenatal and post-natal care and care for complications of pregnancy. With regard to post-parturition care, coverage is as follows: (1) a minimum of 48 hours of inpatient care for the mother and newborn, following a vaginal delivery, or (2) a minimum of 96 hours of inpatient care for the mother and newborn, following a delivery by caesarian section. A shorter length of stay for services related to maternity and newborn care may be provided if the Attending Physician determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and the newborn meet the appropriate guidelines for that length of stay based upon

evaluation of the mother and newborn. If a shorter length of stay is determined to be appropriate in accordance with these guidelines, the mother and newborn are entitled to an office visit or home-nurse visit within 48 hours of discharge.

ARTICLE VII - PSYCHIATRIC, MENTAL HEALTH, AND SUBSTANCE ABUSE INCLUDING ALCOHOLISM BENEFITS

7.1 Hospital Services or medical care under this Contract shall be covered, subject to the limitations in Attachment D, only when provided by a Primary Care Physician, except in the event of a Medical Emergency or with a Preauthorized Referral. "Non-acute hospital" as used in this Article means a facility which is not licensed to operate as an acute care general hospital.

7.1.1 **Inpatient Facility Services** - If an Enrollee is confined as a resident inpatient in a Participating Hospital, non-acute hospital, or other UnitedHealthcare authorized residential treatment facility and enrolled in a treatment program authorized by UnitedHealthcare for a psychiatric, mental, or nervous condition or disorder or substance abuse including alcoholism, benefits will be paid in an amount equal to the hospital's regular daily rate for semiprivate accommodations less any applicable Copayments, Coinsurance and Deductibles. In private accommodations, the Enrollee shall pay directly to the Participating Hospital, non-acute hospital, or residential treatment facility the difference between its regular charge for the private room occupied and its most common charge for semiprivate accommodations, as well as any applicable Copayments, Coinsurance and Deductibles. However, if private accommodations are authorized as medically necessary by a Primary Care Physician the Enrollee shall be entitled to full coverage less any applicable Copayments, Coinsurance and Deductibles.

7.1.2 **Outpatient Facility Services** - Outpatient facility service benefits will be paid if an Enrollee shall receive necessary hospital outpatient medical services at a Participating Hospital, non-acute Hospital, or other UnitedHealthcare authorized treatment facility and be enrolled in an UnitedHealthcare-authorized outpatient treatment program for a psychiatric, mental, or nervous condition or disorder or substance abuse including alcoholism.

7.2 **Physician Services** - If an Enrollee shall receive necessary psychiatric or professional services by: (1) a Primary Care Physician acting within the scope of his or her licensed authority, or (2) other licensed mental health provider with a Preauthorized Referral for a psychiatric, mental or nervous condition or disorder or substance abuse including alcoholism, benefits will be paid subject to the following provisions:

7.2.1 **Hospital Inpatient Physician Services** - Hospital inpatient physician service benefits will be paid if the Enrollee is confined as a resident inpatient in a hospital as described in Article VII, 7.1.1.

7.2.2 **Hospital Outpatient Physician Services** - Hospital outpatient physician service benefits will be paid if the Enrollee shall receive necessary hospital outpatient services as described in Article VII, 7.1.2.

7.2.3 **Physician Office Services** - Physician office service benefits will be paid if the Enrollee receives necessary physician office services.

7.3 **Biologically-based Mental Illness** - Benefits will be paid for mental illness, including Biologically Based Mental Illness, and coverage will be neither different nor separate from coverage for any other illness, condition, or disorder, for purposes of determining any Deductible, Copayment, or Coinsurance amounts.

"Biologically Based Mental Illness" as used in this section means the following psychiatric illnesses as defined by Iowa Insurance Division, based on the definitions provided in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association which may be amended from time to time:

(1) Schizophrenia.
(2) Bipolar disorders.
(3) Major depressive disorders.
(4) Schizoaffective disorders.
(5) Obsessive-compulsive disorders.
(6) Pervasive developmental disorders.
(7) Autistic disorders.

7.4 **Benefits Not Provided** - Benefits will not be provided under Article VII for:

7.4.1 for any day of confinement, service provided, or examination made which is not authorized by a Primary Care Physician, except in the event of a Medical Emergency or with a Preauthorized Referral;

7.4.2 for charges made by any person other than a Participating Provider unless approved by UnitedHealthcare;

7.4.3 for charges incurred for services, other than diagnostic services, for mental retardation or for non-treatable mental deficiency;

7.4.4 for charges incurred for the treatment of a mental or nervous disorder which is not subject to favorable modification by accepted psychiatric treatment;

7.4.5 for marital problems;

7.4.6 for family therapy, except as related to a covered service for another family member;

7.4.7 for learning problems;

7.4.8 for adult or childhood antisocial behavior without manifestation of a psychiatric disorder;

7.4.9 for aggressive or nonaggressive conduct disorder without manifestation of a psychiatric disorder;

7.4.10 for general counseling and advice;

7.4.11 for charges for personal and convenience items such as telephone, television, personal care items and personal services or for charges for diversional activities such as recreational, hobby or craft equipment or fees.

ARTICLE VIII - PERIOD AND EXTENT OF BENEFITS FOR EACH ENROLLEE

8.1 If an Enrollee remains in a Participating Hospital or Nursing Facility after having been advised by a Primary Care Physician and notified by UnitedHealthcare that further confinement is medically unnecessary and benefits are no longer available, the Enrollee shall be responsible for all charges incurred for services provided subsequent to such notification.

8.2 If any services not included in or covered by this Contract are provided to an Enrollee, or if any Copayment, Coinsurance or Deductible applies as described in Attachment D, the Enrollee shall make direct payment to the provider of such services.

ARTICLE IX – EXCLUSIONS APPLICABLE TO THE CONTRACT

In addition to specific exclusions listed under individual Articles, benefits shall not be provided for any of the following services, treatment, conditions, charges, fees, or items:

9.1 Any service or treatment which is not medically necessary, as described and defined in Article III, section 3.2, or any medical complication resulting from a treatment, procedure, or device which is not covered under this Contract.

9.2 Any service or treatment, hospital, medical, or otherwise, which is not provided by a Primary Care Physician or arranged or approved by a Primary Care Physician with a Participating Provider, except in the event of a Medical Emergency, with a Preauthorized Referral, or when point-of-service benefits are payable.

9.3 Shift care, 24-hour nursing, private or special duty nursing services in the hospital, home or Nursing Facility, unless determined to be medically necessary and authorized in advance by UnitedHealthcare.

9.4 Care for conditions that federal, state or local law requires be treated in a public facility, hospital or other health care facility.

9.5 If the Enrollee's condition is custodial, which means that his or her care consists of watching, maintaining, protecting, or is for the purpose of providing personal needs, UnitedHealthcare does not pay for a person or facility to provide any of, but not limited to, the following:

9.5.1 assistance in the activities of daily living, such as walking, dressing, getting in and out of bed, bathing, eating, feeding or using the toilet or help with other functions of daily living or personal needs of a similar nature;

9.5.2 changes of dressings, diapers, protective sheets or periodic turning or positioning in bed;

9.5.3 administration of or help in using or applying medications, creams and ointments, whether oral, inhaled, topical, rectal or injection;

9.5.4 administration of oxygen;

9.5.5 care or maintenance in connection with casts, braces, or other similar devices;

9.5.6 care in connection with ostomy bags or devices or in-dwelling catheters;

9.5.7 feeding by tube including cleaning and care of the tube site;

9.5.8 tracheostomy care including cleaning, suctioning and site care;

9.5.9 urinary bladder catheterization;

9.5.10 monitoring, routine adjustments, maintenance or cleaning of an electronic or mechanical device used to support a physiological function including, but not limited to, a ventilator, phrenic nerve or diaphragmatic pacer; or

9.5.11 general supervision of exercise programs including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled rehabilitation services.

9.6 Hospital, personal care or convenience items or services including, but not limited to: television, telephone, newborn infant photos, complimentary meals, birth announcements, and other articles which are not for specific treatment of illness or injury. Also, benefits are not provided for:

9.6.1 private room or special diets unless medically necessary; or

9.6.2 housekeeping, homemaker service, and caregiver room/board; or

9.6.3 purchase or rental of household equipment or fixtures such as air purifiers, central or unit air conditioners, water purifiers, non-allergenic pillows, mattresses, waterbeds, escalators, elevators, saunas, or swimming pools; or

9.6.4 charges for diversional activities such as recreational, hobby or craft equipment or fees.

9.7 Surgical excision or reformation of any sagging skin on any part of the body including but not limited to eyelids, face, neck, abdomen, arms, legs, or buttocks; any services performed in connection with enlargement, reduction, implantation, or change in appearance in any portion of the body including, but not limited to, breasts, face, lips, jaw, chin, nose, ears or genitals; hair transplantation; chemical face peels or abrasions of skin; electrolysis depilation; treatment of birthmarks or superficial veins; any other surgical or non-surgical procedures which are performed for cosmetic purposes. However, benefits will be payable for certain reconstructive surgery as described in Article VI, section 6.1.12.

9.8 Any fees for the services of non-physician Participating or Non-Participating Providers if such fees or charges are claimed by hospitals, laboratories, or other institutions or for the service of any assisting physician not authorized by a Primary Care Physician.

9.9 Any fees involving any types of services in connection with dentistry such as but not limited to:

a) the care, filling, removal or replacement of teeth or of the structures supporting the teeth; or

b) surgical augmentation for orthodontics or maxilla (upper jaw) or mandible (lower jaw) construction; or

c) orthognathic surgery, which refers to any surgical procedure performed to correct skeletal malposition or misalignment of the maxilla and/or mandible, including osteotomy or condylotomy.

Exceptions to this exclusion are as follows:

9.9.1 Reconstructive surgery as provided in Article VI, 6.1.12; or

9.9.2 Surgical and non-surgical procedures, approved in advance by UnitedHealthcare, resulting directly from: (a) neoplasms that require treatment to the jaws, cheeks, lips, tongue, or roof or floor of mouth, or (b) injury to natural permanent teeth. A Preauthorized Referral will be required if such treatment is performed by a Non-Participating Provider. “Injury to natural permanent teeth” does not include fractures of restorations or teeth resulting from routine daily functions; or

9.9.3 if dental coverage is provided in a supplemental benefits rider attached hereto; or

9.9.4 Coverage for medically necessary treatment of temporomandibular or craniomandibular joint syndrome (TMJ) as described in Article V, section 5.1.7.

9.10 The following items, unless coverage is provided in a supplemental benefits rider attached hereto:

9.10.1 dental prostheses; or

9.10.2 eye glasses or contact lenses; or

9.10.3 hearing aids.

9.11 Augmentative communication devices unless medically necessary.

9.12 Special shoes unless an integral part of a brace or part of diabetes treatment; corrective footwear; foot orthotic devices and supplies unless part of diabetes treatment; routine foot care including trimming of corns, calluses and nails; corsets unless part of diabetes treatment, other articles of clothing, or cosmetic devices.

9.13 Treatment provided in a government hospital; services performed by an Enrollee for an Enrollee's immediate family; and services for which no charge is normally made.

9.14 Services for any illness, injury or disease that is covered, in whole or in part, by an employer's plan or coverage designed to comply with any state or federal workers' compensation, employer's liability or occupational disease law (collectively, workers' compensation law), or with respect to the Subscriber, any illness, injury or disease that could be covered, in whole or in part, by such a plan or coverage if the employer had such a plan or coverage. If UnitedHealthcare makes payment for such services, it shall be entitled to a lien upon any amounts it paid for which the employer's workers' compensation plan or coverage should have been liable.

9.15 Any service which can be performed in the setting by a person who does not have professional qualifications but has been trained to perform the service.

9.16 Experimental and/or investigational drugs, devices, medical treatments or procedures, including any complication arising therefrom. A drug, device, medical treatment or procedure is experimental and/or investigational if:

9.16.1 the drug or device requires approval of the Food and Drug Administration and the drug or device has not been approved when furnished (a drug or device approved for experimental and/or investigational use is deemed to be experimental and/or investigational); or

9.16.2 the drug, device, medical treatment or procedure is being provided according to a written protocol which describes as an objective determining the safety, toxicity, efficacy or effectiveness of the drug, device, medical treatment, or procedure as compared with the standard means of treatment or diagnosis for the Enrollee's medical condition; or

9.16.3 reliable evidence shows that the consensus of opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated doses, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis for the Enrollee's medical condition.

For the purposes of this Article, "reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature.

Treatment provided in a phase I, II, or III clinical trial will be deemed to be experimental and/or investigational unless reliable evidence establishes that the treatment is not experimental and/or investigational for the Enrollee's medical condition. Exception: "Patient costs" incurred as a result of an Enrollee's participation Certain National Cancer Institute-approved and National Institutes of Health-approved phase III clinical trials for cancer are covered as described in section 5.1.9.

9.17 Biofeedback treatment, except in conjunction with physical therapy performed for the treatment of urinary incontinence.

9.18 Holistic medicine; massage therapy; acupuncture; hypnotherapy; sleep therapy; vocational, rehabilitational or employment counseling; marriage and sex counseling; behavior training, conduct disorders and related family counseling; remedial education and treatment of learning disabilities.

9.19 Ergometers, exercise bikes, or other similar equipment or devices.

9.20 Diet or weight loss programs, dietary supplements, nutritional formulas and supplements, and megavitamin therapy.

Exceptions to this exclusion are as follows:

a) Medical nutritional therapy will be covered up to two medically necessary visits per calendar year for hypertension and myocardial infarction; or

b) Medical nutritional therapy will be covered under a diabetes self-management program as described in Article V, section 5.1.10.

9.21 Illness contracted or injuries sustained as the result of war, declared or undeclared, or any act or hazard of war.

9.22 Illness contracted or injuries sustained as the result of or while in armed services of any country to the extent that the Enrollee is entitled to coverage for illness or injury through any governmental plan or program except Medicaid.

9.23 Outpatient prescription drugs unless provided in a supplemental benefits rider attached hereto; other drugs or medications except when provided to Enrollee in an inpatient setting.

9.24 Hospital or physician services or treatment provided as a result of a court order unless approved in advance by a Primary Care Physician.

9.25 Charges incurred in connection with: (a) any testing or procedure to support a diagnosis of infertility; or (b) any assisted reproduction techniques, such as, but not limited to, artificial insemination and in vitro fertilization, reversal of vasectomies, reversal of tubal ligations or the reversal of other voluntary sterilization procedures unless provided in a supplemental benefits rider attached hereto.

9.26 Any treatment or procedures related to the performance of gender transformation.

9.27 Surgery to the cornea to improve vision by changing the refraction, such as but not limited to radial keratotomy or LASIK (laser assisted in-situ keratomileusis).

9.28 Physical exams and any related diagnostic testing required for employment, licensing, immigration, insurance, adoption, school, camp or sports participation when services will result in duplication of UnitedHealthcare benefits for routine preventive care. Immunizations for the purpose of obtaining or maintaining employment are also excluded.

9.29 Any fees relating to any types of services or items resulting from an injury sustained as a result of Enrollee's commission of, or attempt to commit, a felony. Upon Enrollee's conviction, UnitedHealthcare will be entitled to reimbursement of any claims paid as a result of such an injury..

9.30 Any health care services which are covered under a motor vehicle no-fault insurance policy or other liability or equivalent self-insurance.

9.31 Occupational therapy shall not include vocational therapy, vocational rehabilitation, educational, or recreational therapy.

9.32 Speech therapy except as required for a residual speech impairment resulting from a stroke, accidental injury or surgery to the head or neck.

9.33 Charges of a Non-Participating Provider in excess of Reasonable and Customary, unless due to a Medical Emergency or Preauthorized Referral.

9.34 Surgical treatment and associated care for treatment of obesity.

9.35 Drugs, medicines, or any implants or devices used in conjunction with birth control regardless of intended use unless provided in a supplemental benefits rider attached hereto.

9.36 Performance of an injection by a nurse or physician which would normally be self-administered, except in an inpatient setting.

9.37 Organ and tissue transplant services provided by Participating Providers that are not UnitedHealthcare-approved transplant centers or by Non-Participating Providers. Charges associated with more than one transplant center waiting list are also excluded. Organ and tissue transplant services are payable only as described in section 5.1.6.

9.38 Telephone or email consultations, charges for failure to keep scheduled appointments, charges for completion of any form, or charges for copying medical records.

9.39 Charges for non-used medication.

9.40 Replacement of items that are lost, stolen, misused, otherwise abused, or damaged due to neglect or accident.

9.41 Charges in excess of any Lifetime Maximum amount shown in Attachment D for each Enrollee.

9.42 Services provided to an Enrollee as part of a demonstration project conducted or sponsored by the Centers for Medicare & Medicaid Services (CMS).

ARTICLE X - GENERAL CONDITIONS UNDER WHICH BENEFITS SHALL BE PROVIDED

10.1 The benefits of this Contract are subject to the terms and conditions described herein. UnitedHealthcare shall not have liability or obligation for services not provided by a Primary Care Physician, except in the event of a Medical Emergency or with a Preauthorized Referral.

10.2 Payment for professional services included under this Contract shall be arranged for by UnitedHealthcare and paid to the provider of services, or, at the sole discretion of UnitedHealthcare, directly to the Enrollee in the case of Non-Participating Provider services

10.3 Hospital Service is subject to all the rules and regulations of the Participating Hospital or Nursing Facility, including the rules and regulations governing admission and discharge. No inpatient or outpatient services will be covered if the admission or other services are provided by a Non-Participating Provider except in the event of a Medical Emergency or with a Preauthorized Referral.

10.4 The Enrollee agrees that any complaint or Appeal regarding this Contract or the provision of benefits under this Contract shall be submitted for resolution in accordance with the Enrollee Complaint, Appeal and Dispute Resolution procedure established by UnitedHealthcare as set forth in Article XVII.

10.5 The Enrollee agrees that in the event the Primary Care Physician for the Enrollee ceases to be a Participating Physician, the Enrollee shall choose another Primary Care Physician.

10.6 In the event of any major disaster or epidemic, war, riot or labor dispute, UnitedHealthcare shall provide hospital and medical services provided under this Contract in so far as practical, according to its best judgment, within the limitations of such facilities and personnel as are then available. Under such conditions UnitedHealthcare shall not have any liability or obligation for delay or failure to provide or arrange for hospital or medical services due to lack of available facilities or personnel.

10.7 The Enrollee agrees to provide UnitedHealthcare all information relating to duplicate insurance or other coverage for which there may be coordination of benefits.

ARTICLE XI - RELATIONSHIP AMONG PARTIES AFFECTED BY THE CONTRACT

11.1 The relationship between UnitedHealthcare and any person or organization having a contract with UnitedHealthcare is an independent contractor relationship. No such organization or employee or agent thereof is an employee or agent of UnitedHealthcare, and neither is UnitedHealthcare nor any employee or agent of UnitedHealthcare an employee or agent of such organization.

11.2 Participating Physicians maintain the physician-patient relationship with Enrollees and are solely responsible to Enrollees for all medical services.

11.3 The Enrollee is not an agent or representative of UnitedHealthcare, and shall not be liable for any acts or omissions of UnitedHealthcare, its agents or employees, or any other person or organization with which UnitedHealthcare has made or hereafter shall make arrangements for the performance of services under this Contract.

11.4 UnitedHealthcare has entered into a service agreement with its parent, UnitedHealthcare Services Company of the River Valley, Inc. UnitedHealthcare Services Company of the River Valley, Inc. provides all administrative services for UnitedHealthcare.

ARTICLE XII - CLAIM PROVISIONS

12.1 Except as set forth in Attachment D, it is not anticipated that an Enrollee will make payment to any Participating Provider performing a covered service under this Contract beyond any applicable Copayment, Coinsurance and Deductible. However, if the Enrollee furnishes evidence satisfactory to UnitedHealthcare that he or she has made payment to a Participating Provider for performing a covered service under this Contract, payment for those charges will be made to the Enrollee, but in no event will the amount of payment to the Enrollee exceed the maximum benefit payable by UnitedHealthcare less any applicable Copayment, Coinsurance and Deductible.

12.2 If a charge is made to an Enrollee by a Participating Provider for performing a covered service under this Contract beyond any applicable Copayment, Coinsurance and Deductible, written proof of such charges should be furnished to UnitedHealthcare within 90 days from the date of service. Payment for such charges will not be made to the Enrollee if evidence of payment is submitted more than fifteen months after the date of service.

12.3 Charges for a covered service performed by a Non-Participating Provider due to a Medical Emergency or with a Preauthorized Referral will be paid to the Enrollee, or to the Non-Participating Provider if there is a written assignment of benefits, after written proof of charges is furnished to UnitedHealthcare within 24 months from the date the service was performed. Payment for such charges will not be made to the Enrollee, or Non-Participating Provider through a written assignment of benefits, if written proof of such charges is not furnished to UnitedHealthcare within this 24-month period.

ARTICLE XIII - PREMIUMS

13.1 Only Enrollees for whom Group has paid the Premium shall be entitled to benefits for the period for which such payment has been received. UnitedHealthcare will allow Group a grace period of 31 days following the Premium due date. This Contract shall stay in force during the grace period. If payment is not received before the end of the grace period, coverage will be terminated at the end of the grace period with prior notice to Group but without prior notice from UnitedHealthcare to Enrollees. Group and/or Enrollees will be held liable for benefits received during the grace period.

13.2 Group or its delegate is the plan administrator under federal law including, but not limited to, the Employee Retirement Income Security Act (ERISA) and is responsible for various duties as plan administrator including, but not limited to, notice to enrollees of suspension or termination of coverage and reporting and disclosure requirements. UnitedHealthcare is not the plan administrator. Group, or its delegate, but not UnitedHealthcare, is responsible for complying with the health care continuation provisions in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, or any applicable state law.

ARTICLE XIV - TERMINATION

14.1 In addition for termination for non-payment of Premium as explained in Article XIII, 13.1, UnitedHealthcare may terminate this Contract at any time for one or more of the following reasons:

14.1.1 Death of the Subscriber: Upon the death of the Subscriber this Contract shall automatically terminate. For coverage rights, if any, of surviving Eligible Dependents, see Article XV, Continuation of Coverage.

14.1.2 Subscriber no longer eligible: If the Subscriber is no longer eligible to participate in the health benefits plan offered by Group under this Contract, this Contract shall automatically terminate. For coverage rights, if any, of Subscriber and Eligible Dependents, see Article XV, Continuation of Coverage.

14.1.3 Fraud or misrepresentation of a material fact in enrolling or making claim for benefits under this Contract. Under such circumstances, UnitedHealthcare shall have the right to recover the full amount of any benefits paid on behalf of the Enrollee.

14.1.4 The unauthorized use of an Enrollee's UnitedHealthcare identification card by any other persons in which case such card may be retained by UnitedHealthcare and all rights of such Enrollee and, if such Enrollee is a Subscriber, all rights of his or her Eligible Dependents shall terminate.

14.1.5 Change in status as Eligible Dependent: If an Enrollee is no longer within the definition of an Eligible Dependent, his or her benefits shall terminate automatically and without notice. For coverage rights, if any, see Article XV, Continuation of Coverage.

14.1.6 Failure of the Enrollee to pay Copayments, Coinsurance and/or Deductibles.

14.1.7 Refusal of the Enrollee to follow a prescribed course of treatment and/or instruction as established by a Primary Care Physician.

14.1.8 If the Enrollee engages in activities which endanger the safety and welfare of UnitedHealthcare or its employees or providers.

14.1.9 Expiration of the maximum continuation of coverage period.

14.1.10 Such other reasons as may be approved by the appropriate regulatory agencies of the state of operation.

14.2 If the Group Health Contract which covers the Enrollee terminates, this Contract shall terminate at the same time. If required by law, UnitedHealthcare shall give the Enrollee written notice prior to termination.

14.3 Upon termination of enrollment as provided in this Article or Article XIII, Enrollee shall cease to be entitled to any benefits under this Contract. However, if Enrollee remains in a hospital or Nursing Facility at the time of such termination, Enrollee shall be entitled to an extension of benefits, subject to the terms and conditions of this Contract, for that confinement. Such an extension of benefits for hospital or Nursing Facility services shall cease with the earliest occurrence of one of the following events:

14.3.1 Enrollee is discharged from the hospital or Nursing Facility; or

14.3.2 Enrollee becomes covered under another group health plan; or

14.3.3 60 days has elapsed from the date this Contract terminated.

14.4 Except as provided in this Article, UnitedHealthcare must renew this Contract at the option of the Group, unless:

14.4.1 Group fails to pay Premiums or contributions in accordance with the terms of this Contract.

14.4.2 Group performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of the coverage or, with respect to coverage of an Enrollee, fraud, or intentional misrepresentation by the Enrollee or the Enrollee's representative. If the fraud or intentional misrepresentation is made by a person with respect to any person's prior health condition, UnitedHealthcare has the right to deny coverage to that person or to impose as a condition of continued coverage the exclusion of the condition misrepresented.

14.4.3 Group violates participation or contribution rules.

14.4.4 No Enrollee of Group lives, resides, or works in UnitedHealthcare's authorized Service Area as identified in Attachment C.

14.4.5 UnitedHealthcare ceases to offer a particular type of health insurance coverage in such market in accordance with applicable state law. If UnitedHealthcare decides to discontinue such product that has been purchased by Group, UnitedHealthcare will meet the following requirements:

14.4.5.1 Provide written notice to Group and each Subscriber covered under this Contract, of the discontinuation of such product at least 90 days before the discontinuation of coverage;

14.4.5.2 Offer to Group the option on a guaranteed basis to purchase any other health insurance coverage currently being offered by UnitedHealthcare in such market;

14.4.5.3 In exercising the option to discontinue such product and in offering the option of coverage under section 14.4.5.2, UnitedHealthcare will act uniformly without regard to claims experience of those Groups or any health status-related factor relating to any Enrollees who may become eligible for such coverage.

14.4.6 UnitedHealthcare elects to discontinue offering all health insurance coverage in the State of Iowa. Health insurance coverage may be discontinued by UnitedHealthcare only in accordance with applicable state law and if:

14.4.6.1 UnitedHealthcare provides written notice to the Iowa Insurance Division and to Group and each Subscriber covered under this Contract, at least 180 days prior to the discontinuation of coverage; and

14.4.6.2 All affected group health contracts issued or delivered for issuance in the State of Iowa are discontinued and coverage is not renewed.

14.5 A certificate of creditable coverage will be provided in accordance with state and federal law. Also, an Enrollee may request a certificate of creditable coverage by contacting UnitedHealthcare at the appropriate address or toll-free telephone number listed in Attachment E.

ARTICLE XV - CONTINUATION OF COVERAGE

15.1 **Continuation Coverage Under Federal or State Law.** If benefits under this Contract terminate due to a loss of eligibility according to the eligibility requirements established by UnitedHealthcare, continuation of coverage shall be provided if required under the terms and conditions of any applicable federal law or state laws.

ARTICLE XVI - REINSTATEMENT AND MISCELLANEOUS PROVISIONS

16.1 Any Contract which is terminated in any manner as provided herein may be reinstated by UnitedHealthcare at its sole discretion.

16.2 The benefits of this Contract are personal to Enrollee and shall not be assigned, delegated, or transferred.

16.3 Applicants for enrollment shall complete and submit to UnitedHealthcare such applications, medical review questionnaires, or other forms or statements as UnitedHealthcare may reasonably request. Applicants agree that all information contained in such materials shall be true, correct and complete to the best of their knowledge and belief.

16.4 Enrollees may request additional identification cards, free of charge, by contacting UnitedHealthcare at the telephone number provided in Attachment E. Any cards issued by UnitedHealthcare to Enrollees pursuant to this Contract are for identification only. Possession of a UnitedHealthcare identification card confers no right to services or other benefits under this Contract. To be entitled to such services or benefits, the holder of the card must, in fact, be an Enrollee on whose behalf all applicable charges under this Contract have actually been paid. Any person receiving services or other benefits to which he or she is not entitled pursuant to the provisions of this Contract shall be charged at prevailing rates.

16.5 UnitedHealthcare may receive rebates from pharmaceutical manufacturers. Rebates are the exclusive property of UnitedHealthcare and will not be considered when determining an Enrollee's cost-sharing obligations, such as any applicable Copayment, Coinsurance, or Deductible.

16.6 UnitedHealthcare may adopt reasonable policies, procedures, rules and interpretations to promote orderly and efficient administration of this Contract.

16.7 This Contract constitutes the entire Contract between the parties and, as of the Effective Date hereof, supersedes all other agreements, oral or otherwise, between the parties regarding the subject matter of this Contract and must not be altered or amended except in writing.

16.8 By electing coverage pursuant to this Contract, or accepting benefits under this Contract, all Enrollees and their applicable legal representatives expressly agree to all terms, conditions and provisions of this Contract.

16.9 No agent or other person, except an officer of UnitedHealthcare, has authority to waive any conditions or restrictions of this Contract; to extend the time for making a payment; or to bind UnitedHealthcare by making any promise or representation or by giving or receiving any information. No change in this Contract shall be valid unless evidenced by an endorsement on it signed by one of the aforesaid officers, or by an amendment to it signed by Group and by one of the aforesaid officers, and filed with the Iowa Insurance Division or other appropriate regulatory agencies of the State of operation.

ARTICLE XVII - ENROLLEE COMPLAINT, APPEAL, AND DISPUTE RESOLUTION PROCEDURES

17.1 This Article sets forth a formal system for resolving Complaints and Appeals by Enrollees concerning coverage determinations, the provision of health care services or other matters concerning the operation of UnitedHealthcare.

17.2 The following definitions apply to this Article XVII:

17.2.1 **Appeal** – a Complaint, which having been reported to UnitedHealthcare by the Enrollee and remaining unresolved to the Enrollee's satisfaction, is filed for formal proceedings as set forth in this Article XVIII.

17.2.2 **Authorized Representative** – The Enrollee's guardian or an individual the Enrollee has authorized to act on his or her behalf, including but not limited to the Enrollee's Physician.

17.2.3 **Complaint** - an oral or written expression of dissatisfaction of a problem relating to the policies or the services provided by UnitedHealthcare.

17.2.4 **Post-Service Claim** – any claim for a benefit that is not a Pre-Service Claim.

17.2.5 **Pre-Service Claim** – any claim for a benefit with respect to which the terms of the Contract condition receipt of the benefit, in whole or part, on approval of the benefit in advance of obtaining medical care.

17.2.6 **Urgent Care Claim** – any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: a) could seriously jeopardize the life or health of the Enrollee or the ability of the Enrollee to regain maximum function, or b) in the opinion of a Physician with knowledge of the Enrollee's medical condition, would subject the Enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

17.3 Most Complaints can be resolved satisfactorily on an informal basis by consultation between the Enrollee, UnitedHealthcare staff, and/or the health care practitioner from whom the Enrollee has received services. If an Enrollee's Complaint is not resolved through informal consultation, the Enrollee or Enrollee's Authorized Representative may request a formal Appeal. If the Enrollee wants to designate an Authorized Representative to assist him or her with this Appeal Process, this must be done in writing. An Enrollee's Authorized Representative may not file a formal Appeal without explicit, written designation by the Enrollee.

17.4 ***Expedited Appeal Procedure for Urgent Care Claims –*** For Urgent Care Claims, the Enrollee or Enrollee's Authorized Representative may contact UnitedHealthcare, orally or in writing, to request expedited consideration of the Enrollee's formal Appeal.

17.4.1 In determining whether a claim is for urgent care, UnitedHealthcare will apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If the request for expedited consideration is denied by UnitedHealthcare, the Enrollee's or Enrollee's Authorized Representative's Appeal will automatically be reviewed by UnitedHealthcare according to the Appeal Procedure provided in section 17.5. The request for expedited consideration will not be denied if a Physician with knowledge of the Enrollee's medical condition determines that a claim

involves urgent care.

17.4.2 Within 72 hours after UnitedHealthcare has received request for expedited handling which includes all necessary information, UnitedHealthcare will issue a decision to the Enrollee or Enrollee's Authorized Representative by telephone or facsimile. If additional information is needed by UnitedHealthcare to review the expedited Appeal, the Enrollee or Enrollee's Authorized Representative will be notified within 24 hours of receipt of the expedited Appeal specifying the information needed by UnitedHealthcare to make a decision. When the additional information is received by UnitedHealthcare, a final decision will be made within 48 hours of receipt of the specified information or at the end of the period given to provide the specified information, whichever is earlier.

17.4.3 Written confirmation of the final decision will be mailed to the Enrollee within three calendar days.

17.4.4 If the Enrollee or the Enrollee's Authorized Representative is not satisfied with the decision described in section 17.4.2, he or she may request an External Independent Review (EIR) as provided in section 17.6.

17.5 ***Appeal Procedure for Pre-Service and Post-Service Claims that are not Urgent Care Claims*** – For Pre-Service and Post-Service Claims that are not Urgent Care Claims, the Enrollee or Enrollee's Authorized Representative may request an Appeal by completing a written "Appeal Form," which shall be provided by UnitedHealthcare upon the written or oral request of the Enrollee or Enrollee's Authorized Representative. The Appeal Form must be completed and filed to UnitedHealthcare within 180 days from the date: (1) the Enrollee received notification of a denial of coverage; or (2) the problem in question occurred. The Appeal Form shall be completed and signed and the facts as alleged shall be binding on Enrollee. The Appeal Form shall be filed by mail, facsimile, or hand-delivery to UnitedHealthcare, in accordance with instructions provided with the Appeal Form.

17.5.1 For determinations as to whether a specific service, procedure, or treatment is medically necessary (described in Article III, section 3.2) or for any other determination requiring medical judgment, UnitedHealthcare shall issue a decision, in writing, to all parties involved within the following timeframes:

- Pre-Service Claim: 30 calendar days after receipt of Appeal Form.
- Post-Service Claim: 60 calendar days after receipt of Appeal Form.

If the Enrollee or Enrollee's Authorized Representative is not satisfied with the decision described in this section 17.5.1, the Enrollee or Enrollee's Authorized Representative may request an External Independent Review (EIR) as provided in section 17.6.

17.5.2 For all other Appeals that are not Urgent Care Claims, UnitedHealthcare shall issue a decision, in writing, to all parties involved within the following timeframes:

- Pre-Service Claim: 15 calendar days after receipt of Appeal Form.
- Post-Service Claim: 30 calendar days after receipt of Appeal Form.

If the Enrollee or Enrollee's Authorized Representative is not satisfied with the decision described in this section 17.5.2, the Enrollee or Enrollee's Authorized Representative may request a reconsideration of the Appeal decision, as provided in section 17.7.

17.6 ***External Independent Review:*** An Enrollee, Enrollee's Authorized Representative, or the Attending Physician acting on behalf of Enrollee, may request external independent review of an adverse decision resulting from an Appeal described in section 17.4 or section 17.5.1. These provisions for EIR are not to be construed to require payment for any health care treatment or service which is not covered under Enrollee's Subscriber Agreement. A service or treatment which is specifically stated to be excluded from coverage in this Contract is not eligible for EIR.

17.6.1 Enrollee, or the Attending Physician acting on behalf of Enrollee, may file with the Commissioner of Insurance, by mailing to the address provided in Attachment E, a request in writing within 60 days of UnitedHealthcare's final adverse decision in section 17.4 or section 17.5.1, as described in the letter from UnitedHealthcare conveying that decision, along with a copy of UnitedHealthcare's letter. Enrollee will pay a filing fee of $25 which must accompany the request for EIR, but such filing fee will be refunded if the EIR decision is in favor of Enrollee.

17.6.2 Enrollee must verify to the satisfaction of the Commissioner of Insurance of the State of Iowa that: (1) Enrollee was covered at the time of the proposed treatment; (2) the final adverse decision, denying coverage, was based on the definition of medical necessity as defined in the Subscriber agreement; and (3) Enrollee, or the Attending Physician acting on behalf of Enrollee, has completed all internal Appeal procedures described in section 17.4 or 17.5 and 17.5.1. The Commissioner will have two business days to certify the request after receiving it, if the criteria above have been met and if the written request for EIR was filed within 60 days of UnitedHealthcare's final adverse decision described in section 17.4 or section 17.5.1

17.6.3 UnitedHealthcare has three business days from receipt of the Commissioner's certification either to contest the eligibility of the request for EIR with the Commissioner or to proceed with EIR by selecting an independent review entity certified by the Commissioner to conduct the review and by notifying the Enrollee and the Enrollee's Attending Physician of the name, address, and telephone number of the selected independent review entity. Along with that notification will be a written explanation of the right of the Enrollee (and/or the Enrollee's Attending Physician): (a) to submit additional information to the independent review entity, and/or (b) to object either to the independent review entity selected by UnitedHealthcare or to the person selected by that entity as the reviewer. Upon receiving an objection from the Enrollee (or the Attending Physician acting on behalf of the Enrollee), the Commissioner has two business days to consider the reasons provided in support of the objection, to select an independent review entity, and to notify the Enrollee, the Attending Physician, and UnitedHealthcare.

17.6.4 UnitedHealthcare will provide to the independent review entity copies of all information UnitedHealthcare received and any documents relevant to UnitedHealthcare's final adverse decision described in section 17.4.2 or section 17.5.1. If the independent review entity needs any additional medical information from either Enrollee or Enrollee's Attending Physician, it will notify him or her and will also notify UnitedHealthcare of its request. Enrollee or Enrollee's Attending Physician must submit the requested additional information to the independent review entity by the specified deadline.

17.6.5 The standard of review to be used by an independent review entity shall be whether the health care service or treatment denied by UnitedHealthcare was medically necessary as defined by this Subscriber agreement and consistent with clinical standards of medical practice. The independent review entity shall submit its decision as soon as possible but not more than 30 days from its receipt of all necessary information. Its decision will be delivered to Enrollee or to the Attending Physician acting on behalf of Enrollee, to UnitedHealthcare, and to the Commissioner initially by telephone or facsimile transmission and subsequently by regular mail.

17.6.6 An **expedited** EIR shall be conducted if Enrollee's Attending Physician states that delay would pose an imminent or serious threat to Enrollee's health. Enrollee's Attending Physician and UnitedHealthcare will select a certified independent review entity to conduct the expedited EIR within 72 hours.

If Enrollee's Attending Physician and UnitedHealthcare cannot agree upon selection of an independent review entity, then Enrollee's Attending Physician shall notify the Commissioner, who will select the independent review entity to conduct the expedited EIR.

17.6.7 The EIR decision is binding upon UnitedHealthcare. UnitedHealthcare shall pay all reasonable fees and costs of the independent review entity in conducting the EIR. Enrollee, or the Attending Physician acting on behalf of Enrollee, may appeal the independent review entity's decision by filing a petition for judicial review in district court either in Polk county or in the county of Enrollee's residence. Such petition must be filed within fifteen business days after the EIR decision was issued. Neither UnitedHealthcare nor Enrollee's Attending Physician shall be subject to any penalties, sanctions, or award of damages for complying in good faith with the EIR decision.

17.7 ***Enrollee Reconsideration Procedure:*** The Enrollee or Enrollee's Authorized Representative shall have 30 days from the date the Appeal decision was issued pursuant to section 17.5.2, in which to file a request for reconsideration to the Enrollee Reconsideration Committee of UnitedHealthcare. The Committee meeting shall be held at the UnitedHealthcare home office in Moline, Illinois. Enrollee or Enrollee's Authorized Representative will be notified that the Enrollee Reconsideration Committee will meet to hear his or her case, and Enrollee or Enrollee's Authorized Representative will be provided the opportunity to submit additional information and comments in writing. The Enrollee Reconsideration Committee shall resolve the Appeal by majority vote and shall issue a final written decision to all parties involved within the following timeframes:

- Pre-Service Claim: 15 calendar days after receipt of the request for reconsideration.
- Post-Service Claim: 30 calendar days after receipt of the request for reconsideration.

17.8 After exhausting the Appeal procedure of section 17.4 or section 17.5.1 or the reconsideration procedure of section 17.7, as applicable, if the Enrollee remains dissatisfied, he or she may either request binding arbitration as provided in section 17.9, or if the Group is subject to the Employee Retirement and Income Security Act (ERISA), bring a civil action under section 502(a) of ERISA.

17.9 ***Arbitration:*** Arbitration shall be conducted in accordance with the then-current Employee Benefit Plans Claims Arbitration Rules of the American Arbitration Association. A request for arbitration must be filed with UnitedHealthcare and American Arbitration Association in writing within six months of the date of the decision being arbitrated. The question for the arbitrator will be whether the decision of UnitedHealthcare should be set aside because the decision was arbitrary and capricious. Judgment upon the decision by the arbitrator may be entered in any court having jurisdiction. Each party will bear its own costs and attorney fees. The expenses associated with the arbitration will be shared equally by both parties. Arbitration is final and binding on the parties. The parties waive their right to seek remedies in court, including their right to jury trial, except for enforcement of the decision of the arbitrator. Enrollee and UnitedHealthcare agree that the arbitrator shall have no authority to award punitive damages and waive their right to such damages.

17.10 Upon written request and free of charge, the Enrollee or Enrollee's Authorized Representative may request copies of all documents relevant to an Appeal or reconsideration.

17.11 For further information about any procedure in this Article XVIII, Enrollee may contact either UnitedHealthcare or the Iowa Insurance Division. Addresses are provided in Attachment E.

ARTICLE XVIII - NOTICE

18.1 Any notice given by UnitedHealthcare to Enrollee shall be sufficient if mailed to Enrollee at his or her address as it appears on the records of UnitedHealthcare. It is Enrollee's responsibility to notify the personnel department of his or her Group of any and all changes in address. Any notice shall be deemed delivered when deposited in the United States mail at any post office or postal box with first class postage prepaid.

ARTICLE XIX - THIRD PARTY LIABILITY

19.1 In the event of any payment of benefits for which an Enrollee may have a claim or cause of action against any person or organization, UnitedHealthcare shall be subrogated to all right of recovery of the Enrollee with respect to any judgment, payment or settlement for personal injury. Enrollee agrees as follows:

19.1.1 to fully cooperate with UnitedHealthcare in obtaining information about the loss and its cause;

19.1.2 to notify UnitedHealthcare of any claim for damages made or lawsuit filed on behalf of Enrollee in connection with the loss;

19.1.3 to include the amount of the benefits paid by UnitedHealthcare on behalf of Enrollee in claims for damages against other parties;

19.1.4 to notify UnitedHealthcare of a proposed settlement at least 30 days before any claim or lawsuit is settled in regard to the loss;

19.1.5 to provide UnitedHealthcare with a lien, to the extent of the cash value of these services and supplies provided. Such lien may be filed with the person whose act caused the injuries, his or her agent or a court having jurisdiction in the matter;

19.1.6 to reimburse UnitedHealthcare from any damages collected to the extent of the reasonable cash value of the services and supplies furnished under this Contract for such injuries. Reimbursement will be made immediately upon collection of damages with respect to such Enrollee, whether by action of law, settlement or otherwise;

19.1.7 to pay UnitedHealthcare all costs and expenses, including attorney's fees, which were incurred or expended by UnitedHealthcare in obtaining or attempting to obtain payment from Enrollee if Enrollee fails or refuses to reimburse UnitedHealthcare pursuant to this provision; and

19.1.8 to permit UnitedHealthcare to file a lawsuit in the name of Enrollee against the person whose act caused the injuries.

19.2 UnitedHealthcare shall be reimbursed first from any judgment, payment or settlement, and regardless of whether Enrollee will be fully compensated. If any amount then remains, it shall be given to Enrollee.

ARTICLE XX - COORDINATION OF BENEFITS

20.1 Coordination of Benefits of This Plan with Other Coverage

20.1.1 This Coordination of Benefits provision does not apply to any supplemental benefits rider for prescription drugs under This Plan.

20.1.2 This Coordination of Benefits (COB) provision applies to This Plan when an Enrollee has health care coverage under more than one Plan. “Plan” and “This Plan” are defined below.

20.1.3 If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

20.1.3.1 shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

20.1.3.2 may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. The above reduction is described in Section 20.4, Effect on the Benefits of This Plan.

20.2 **Definitions**

20.2.1 "**Plan**" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

20.2.1.1 Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

20.2.1.2 Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

20.2.1.3 The medical benefits coverage in group, group-type, and individual automobile no-fault and traditional automobile fault type contracts.

20.2.1.4 Each contract or other arrangement for coverage under 20.2.1.1, 20.2.1.2 or 20.2.1.3 is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

20.2.2 "**This Plan**" is the part of the Group Health Contract that provides benefits for health care expenses.

20.2.3 "**Primary Plan"/"Secondary Plan**". The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

20.2.4 "**Allowable Expense**" means a necessary, reasonable, and customary item of expense for health care, subject to the terms and conditions of this Contract, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

20.2.5 "**Claim Determination Period**" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

20.3 **Order of Benefit Determination Rules**

20.3.1 **General.** When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

20.3.1.1 the other Plan has rules coordinating its benefits with those of This Plan; and

20.3.1.2 both those rules and This Plan's rules, in 20.3.2 below, require that This Plan's benefits be determined before those of the other Plan.

20.3.2 **Rules**. This Plan determines its order of benefits using the first of the following rules which applies:

20.3.2.1 **Non-dependent/Dependent**. The benefits of the Plan which covers the person as an employee, member or Subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.

20.3.2.2 **Dependent Child/Parents Not Separated or Divorced**. Except as stated in 20.3.2.3 below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

20.3.2.2.1 the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year, but

20.3.2.2.2 if both parents have the same birthday, the benefits of the Plan which has covered the parent longer are determined before those of the Plan which has covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in 20.3.2.2.1 above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

20.3.2.3 **Dependent Child/Separated or Divorced Parents**. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

20.3.2.3.1 first, the Plan of the parent with custody of the child;

20.3.2.3.2 then, the Plan of the spouse of the parent with the custody of the child, and

20.3.2.3.3 finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of the parent has actual knowledge of those terms, the benefits of that Plan are

determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

20.3.2.4 **Dependent Child/Joint Custody**. If the specific terms of a court order state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, determination of the order of benefits of the Plans covering the child shall follow the order of benefits determination rules outlined in section 20.3.2.2 above.

20.3.2.5 **Active/Inactive Employees**. The benefits of the Plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule 20.3.2.5 is ignored.

20.3.2.6 **Longer/Shorter Length of Coverage**. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or Subscriber longer are determined before those of the Plan which covered that person for the shorter time.

20.3.2.7 **Court Order**. When a court order specifying the responsibility of medical costs is issued, the court order will determine which Plan will be the Primary Plan.

20.4 **Effects on the Benefits of This Plan**

20.4.1 **When This Section Applies**. This Section 20.4 applies when, in accordance with Section 20.3, Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in 20.4.2 below.

20.4.2 **Reduction in this Plan's Benefits**. The benefits of This Plan will be reduced when the sum of:

20.4.2.1 the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

20.4.2.2 the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

20.4.2.3 When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

20.5 **Right to Receive and Release Needed Information** - Certain facts are needed to apply these COB rules. UnitedHealthcare has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. UnitedHealthcare need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts it needs to pay the claim.

20.6 **Facility of Payment** - A payment under another Plan may include an amount which should have been paid under this Plan. If it does, UnitedHealthcare may pay the amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. UnitedHealthcare will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

20.7 **Right of Recovery** - If the amount of the payments made by UnitedHealthcare is more than it should have paid under this COB provision, it may recover the excess from one or more of:

20.7.1 the persons it has paid or for whom it has paid;

20.7.2 insurance companies; or

20.7.3 other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

20.8 The order of primary responsibility stated above shall not apply when the Enrollee is entitled to receive health care services or indemnity benefits (a) under Worker's Compensation or similar law, or (b) in a hospital or facility owned or operated by any government agency. In such case, the primary responsibility shall rest with those persons or agencies having the obligation to provide the health care services or indemnity benefits under (a) or (b) above.

ARTICLE XXI - DISCRETIONARY AUTHORITY OF UNITEDHEALTHCARE

21.1 UnitedHealthcare has discretionary authority to determine eligibility for benefits and to construe and interpret all terms and provisions of this Contract and may delegate its discretionary authority to another person, partnership, corporation or other legal entity.

UnitedHealthcare Plan of the River Valley, Inc.

ATTACHMENT A

Contract Period - The period commencing on January 1, 2007 and ending December 31, 2007, and each 12-month period thereafter unless otherwise terminated as provided in the Article titled "Termination."

Annual Enrollment Period, as used in this attachment, means the designated period during which those persons meeting the eligibility requirements of UnitedHealthcare may enroll in UnitedHealthcare.

Late Enrollee, as used in this attachment, is any applicant for coverage who does not qualify for special enrollment, as defined in Article II of this Contract, or any applicant who did not join UnitedHealthcare when first eligible for coverage.

Eligible individuals who do not elect UnitedHealthcare coverage during an Annual Enrollment Period are considered Late Enrollees.

UnitedHealthcare Plan of the River Valley, Inc.

Attachment B

To participate under this Contract as a Subscriber, an individual must meet the requirements agreed to by the Group and UnitedHealthcare.

To participate under this Contract as an Eligible Dependent, an individual must be one of the following persons:

1) The Subscriber's legal spouse.

2) The Subscriber's unmarried child under age 19. Coverage terminates on the last day of the month in which the child reaches age 19.

3) The Subscriber's unmarried child who is age 19 or over, but under age 99 and enrolled full-time in a recognized course of study. Coverage terminates on the last day of the month in which the child reaches age 99.

4) The Subscriber's unmarried child, regardless of age, who is all of the following:

   a) permanently and totally disabled, if the disability occurred while an Eligible Dependent as defined in 2) or 3) above;

   b) incapable of self-sustaining employment; and

   c) chiefly dependent upon the Subscriber or other care providers for support.

The term "child" means a natural born and legally adopted child, a child who has been placed with the Subscriber for adoption, a stepchild who lives with the Subscriber, or a child who is under the Subscriber's legal guardianship pursuant to a valid order of a United States federal or state court.

UnitedHealthcare may require that the Subscriber furnish proof of continued dependency of any unmarried child or other dependent.

UnitedHealthcare Plan of the River Valley, Inc.

Attachment C

Des Moines Service Area - The geographical area encompassing the counties of Adams, Appanoose, Audubon, Boone, Calhoun, Carroll, Cass, Clarke, Crawford, Dallas, Davis, Decatur, Fremont, Greene, Guthrie, Hamilton, Harrison, Jasper, Jefferson, Keokuk, Lucas, Madison, Mahaska, Marion, Marshall, Mills, Monona, Monroe, Montgomery, Page, Polk, Pottawattamie, Poweshiek, Ringgold, Sac, Shelby, Story, Tama, Taylor, Union, Wapello, Warren, and Wayne in Iowa.

UnitedHealthcare Plan of the River Valley, Inc.

ATTACHMENT D

SCHEDULE OF BENEFITS

Service Category	Benefits Through Network Providers
Deductible	Not applicable
Maximum Out-of-Pocket Expense	Total Copayments shall not exceed $750 per individual per calendar year or $1,500 per family per calendar year.
Emergency Room Facility	$50 Copayment per visit for initial care only of a Medical Emergency. Balance of Allowed Charge paid at 100%. Copayment waived if admitted. **Follow-up care obtained in the emergency room is not covered. Services must be obtained by a participating provider.**
Ambulance	100% of Allowed Charge in a Medical Emergency.
Physician Medical Services	
Routine Physical Examinations including Well-Child Care	$10 Copayment per visit. Balance of Allowed Charge paid at 100%.
Office Visits	$10 Copayment per visit. Balance of Allowed Charge paid at 100%.
Inpatient Hospital Visits and Consultations	100% of Allowed Charge.
Physician Emergency Room Visits	$10 Copayment per visit. Balance of Allowed Charge paid at 100%.
Outpatient Physician Services (other than surgery)	$10 Copayment per visit. Balance of Allowed Charge paid at 100%.
Home Visits or Nursing Facility Visits	$10 Copayment per visit. Balance of Allowed Charge paid at 100%.
Allergy Testing	$10 Copayment per visit. Balance of Allowed Charge paid at 100%.
Allergy Injections	100% of Allowed Charge.
Immunizations	100% of Allowed Charge.
Injections	
Physician's Office	100% of Allowed Charge.
Hospital (Inpatient or Outpatient)	100% of Allowed Charge.

NOTE: Physician's services or other services separately charged may require separate Copayments.

Service Category	**Benefits Through Network Providers**
Hospital Inpatient Services	
Room & Board (Semi-Private)	100% of Allowed Charge.
Miscellaneous	100% of Allowed Charge.
Outpatient Facility or Surgi-Center	100% of Allowed Charge.
Physician Surgical Services	
Office	100% of Allowed Charge.
Outpatient	100% of Allowed Charge.
Inpatient	100% of Allowed Charge.
X-Ray Imaging and Laboratory Services	
Hospital (inpatient or outpatient)	
For treatment of illness or injury	100% of Allowed Charge.
As part of a preventive examination	100% of Allowed Charge.
Office	
For treatment of illness or injury	100% of Allowed Charge.
As part of a preventive examination	100% of Allowed Charge.
Radiation Therapy and Chemotherapy	100% of Allowed Charge.
Low Dose Mammography	
For treatment of illness or injury	100% of Allowed Charge.
As part of a preventive examination	100% of Allowed Charge.

NOTE: X-ray and laboratory services separately charged by an independent laboratory may require separate Copayment, Coinsurance and/or Deductible, beyond the hospital Coinsurance or physician's office Copayment or Coinsurance.

Maternity Services	
Physician Medical Services	$10 Copayment per pregnancy. Balance of Allowed Charge paid at 100%.

NOTE: Physician's services or other services separately charged may require separate Copayments.

Service Category	**Benefits Through Network Providers**
Hospital Inpatient Services	
Room & Board (Semi-Private)	100% of Allowed Charge.
Miscellaneous	100% of Allowed Charge.
Inpatient Newborn Services	
Physician Inpatient Medical Services	$10 Copayment per visit. Balance of Allowed Charge paid at 100%.
Physician Inpatient Surgical Services	100% of Allowed Charge.
Hospital Inpatient Services	
Room & Board (Semi-Private)	100% of Allowed Charge.
Miscellaneous	100% of Allowed Charge.
Outpatient Physical Therapy	$10 Copayment per visit. Balance of Allowed Charge paid at 100%. Maximum 60 outpatient treatment days per calendar year.
Outpatient Occupational Therapy	$10 Copayment per visit. Balance of Allowed Charge paid at 100%. Maximum 60 outpatient treatment days per calendar year.
Outpatient Speech Therapy	$10 Copayment per visit. Balance of Allowed Charge paid at 100%. Maximum 60 outpatient treatment days per calendar year.
Outpatient Respiratory Therapy	$10 Copayment per visit. Balance of Allowed Charge paid at 100%. Maximum 60 outpatient treatment days per calendar year.
Prosthetic Devices	80% of Allowed Charge.
Durable Medical Equipment	80% of Allowed Charge.
Nursing Facility	100% of Allowed Charge. Maximum 120 days per calendar year.
Hearing Services	$10 Copayment per visit. Balance of Allowed Charge paid at 100%. Service limited to one routine hearing exam per calendar year. Hearing aids, batteries and fittings not covered.
Home Health Care	100% of Allowed Charge. **Must be approved in advance by UnitedHealthcare.**
Hospice Care	100% of Allowed Charge. **Must be approved in advance by UnitedHealthcare.**

NOTE: Physician's services or other services separately charged may require separate Copayments.

Service Category	Benefits Through Network Providers
Organ Transplants	
Physician Medical Services	Covered as any other medical condition. See "Physician Medical Services", preceding.
Physician Surgical Services	Covered as any other medical condition. See "Physician Surgical Services", preceding.
Hospital Services	
Room & Board (Semi-Private)	Covered as any other medical condition. See "Hospital Inpatient Services", preceding.
Miscellaneous	Covered as any other medical condition. See "Hospital Inpatient Services", preceding.
Mental Health Services	
Inpatient Facility	100% of Allowed Charge. Maximum 30 inpatient days per calendar year.
Inpatient Physician	100% of Allowed Charge. Maximum 30 inpatient visits per calendar year.
Outpatient Facility	100% of Allowed Charge.
Outpatient Physician	$10 Copayment per visit. Balance of Allowed Charge paid at 100%.
Office	$10 Copayment per visit. Balance of Allowed Charge paid at 100%.
	Maximum combined Mental Health Outpatient and Office visits are limited to 52 visits per calendar year.

NOTE: Physician's services or other services separately charged may require separate Copayments.

Service Category	**Benefits Through Network Providers**
Substance Abuse Services	
Inpatient Facility	80% of Allowed Charge. Maximum 30 inpatient days per calendar year.
Inpatient Physician	100% of Allowed Charge. Maximum 30 inpatient visits per calendar year.
Outpatient Facility	100% of Allowed Charge.
Outpatient Physician	$20 Copayment per visit. Balance of Allowed Charge paid at 100%.
Office	$20 Copayment per visit. Balance of Allowed Charge paid at 100%.
	Maximum combined Mental Health Outpatient and Office visits are limited to 30 visits per calendar year.

NOTE: Treatment of medical complication resulting from abuse of or addiction to alcohol or drugs shall not count toward any of the Substance Abuse maximums shown under this heading. Payment for medical complications will be made as for any other illness.

Temporomandibular Joint Disease (TMJ)	Not covered.

NOTE: Physician's services or other services separately charged may require separate Copayments.

UnitedHealthcare Plan of the River Valley, Inc.

Attachment E

UnitedHealthcare Plan of the River Valley, Inc.
11141 Aurora Avenue
Urbandale, IA 50322
(800) 747-1446

UnitedHealthcare Plan of the River Valley, Inc.
3800- Avenue of the Cities, Suite 200
Moline, Illinois 61265
(800) 747-1446
(800) 884-4327 TDD

If you would like to file a complaint with the Iowa Insurance Division, they can be reached at the following address:

Division of Insurance
State of Iowa
330 Maple Street
Des Moines, Iowa 50319-0065

UnitedHealthcare Plan of the River Valley, Inc.
SUPPLEMENTAL BENEFITS RIDER TO SUBSCRIBER AGREEMENT UNDER GROUP HEALTH CONTRACT

PRESCRIPTION DRUG RIDER

This Outpatient Prescription Drug Benefits rider is subject to all provisions of the Subscriber Agreement under Group Health Contract not in conflict with the provisions of this rider. In the event of such conflict, the provisions in this rider will govern coverage for Outpatient Prescription Drugs.

Section I DEFINITIONS

1. "Co-Marketed Drugs" means equivalent brand name Outpatient Prescription Drugs containing the same active ingredient(s) and that are available from more than one pharmaceutical company.

2. "Compounded Prescription" means an Outpatient Prescription Drug which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA) and which contains at least one ingredient classified as an Outpatient Prescription Drug.

3. "Direct Member Reimbursement" means the Enrollee pays for an Outpatient Prescription Drug at a pharmacy and the Enrollee submits their receipt to UnitedHealthcare for reimbursement.

4. "Formulary" means a listing of Outpatient Prescription Drugs which are approved for use by UnitedHealthcare and which will be dispensed through a Network Pharmacy to Enrollees. This list shall be subject to periodic review and modification by UnitedHealthcare. UnitedHealthcare may receive rebates from the manufacturer for Outpatient Prescription Drugs which are listed on the Formulary.

5. "Network Pharmacy" means a licensed pharmacy which has entered into agreement with UnitedHealthcare to dispense covered drugs to Enrollees.

6. "Network Provider" means a provider who has signed an agreement with UnitedHealthcare to provide services to Enrollees of UnitedHealthcare.

7. "Outpatient Prescription Drug" means a drug which has been approved by the FDA for specific indications and which can, under Federal or State law, be dispensed only pursuant to a Prescription Order. Such medications are labeled "Prescription Only." Insulin and disposable insulin syringes will be considered an Outpatient Prescription Drug for the purposes of payment pursuant to this rider.

8. "Prescription Fill" means the initial quantity of an Outpatient Prescription Drug dispensed pursuant to a Prescription Order.

9. "Prescription Refill" means a subsequent quantity of an Outpatient Prescription Drug dispensed after the initial Prescription Fill.

10. "Prescription Order" means authorization for the dispensing of an Outpatient Prescription Drug, issued by a medical practitioner, who is duly licensed to make such an authorization in the ordinary course of his or her professional practice.

11. "100-Day Supply List" means a listing of Outpatient Prescription Drugs which are approved by UnitedHealthcare for Enrollees to obtain in quantities up to a 100-day supply. This list will be subject to periodic review and modification by UnitedHealthcare.

Section II COVERED DRUGS

1. Outpatient Prescription Drugs (including insulin and disposable insulin syringes) are covered drugs under this benefit rider. Prescriptions must be dispensed in accordance with the UnitedHealthcare. Formulary and must not be otherwise excluded from coverage based upon exclusions listed in this Outpatient Prescription Drug Benefits Rider or in the Subscriber Agreement under Group Health Contract.

   Outpatient Prescription Drugs will be covered for FDA-approved indications and for non-FDA-approved indications if use is a commonly accepted standard of care as indicated by the following official compendia: United States Pharmacopeia Dispensing Information, or American Hospital Formulary Service Drug Information.

   Examples include, but are not limited to:

   Pulmozyme is considered a covered drug only for the FDA-approved indication of cystic fibrosis.

   Retin A is considered a covered drug only for the FDA-approved indication of acne vulgaris.

2. Outpatient Prescription Drugs covered under this Rider must be dispensed pursuant to a Prescription Order authorized by a:

   (a) Network Provider

   (b) Non-network provider with Preauthorized Referral

   (c) Network or non-network provider in the event of medical emergency

Section III COPAYMENTS

1. Outpatient Prescription Drugs filled at a Retail Pharmacy are subject to the following Copayment schedule:

   A. $5 (Level 1 Copayment) applies if:

      1. Network Pharmacy dispenses Generic drug;
         or
      2. Network Pharmacy dispenses disposable insulin syringes;
         or

3. Network Pharmacy dispenses Coumadin®, Dilantin®, Lanoxin®, Synthroid®, or Tegretol®.

B. $15 (Level 2 Copayment) applies if:
Network Pharmacy dispenses a Formulary brand name medication

C. $60 or 25%, whichever is greater, (Level 3 Copayment) applies if:
Network Pharmacy dispenses a non-formulary brand name medication

D. 50% Coinsurance or applicable copayment (whichever is greater) applies if:

1. Network Pharmacy or non-network pharmacy dispenses a Compounded Prescription
2. Enrollee purchases on Outpatient Prescription Drug at a Network Pharmacy or non-network pharmacy and submits paper claim for payment through Direct Member Reimbursement.

2. Outpatient Prescription Drugs filled through Mail Order are subject to the following Copayment schedule:

A. $10 (Level 1 Copayment) applies if:

1. Generic drug dispensed through Mail Order;
or
2. Disposable insulin syringes dispensed through Mail Order;
or
3. Coumadin®, Dilantin®, Lanoxin®, Synthroid®, or Tegretol® dispensed through Mail Order.

B. $30 (Level 2 Copayment) applies if:
Formulary brand name medication dispensed through Mail Order.

C. $60 or 25%, whichever is greater, (Level 3 Copayment) applies if:
Non-formulary brand name medication is dispensed through Mail Order.

3. Classifications of a brand name medication and generic medication are determined by, and subject to continual review and modification by First Data Bank.

4. Retail Pharmacy: The Enrollee is responsible for one Copayment for each 34-day supply or increment thereof. The Enrollee may request up to a 100-day supply of Formulary drugs listed on the 100-day Supply List. The Enrollee is responsible for three Copayments for each 100-day supply Prescription Fill or Prescription Refill purchased at a retail pharmacy.

5. Mail Order: The Enrollee may request up to a 100-day supply of Formulary drugs listed on the 100-Day Supply List. The Enrollee is responsible for only one Copayment for up to a 100-day supply per Prescription Fill or Prescription Refill purchased through mail order.

Section IV EXCLUSIONS

1. Medications available over the counter (OTC) that do not require a prescription.

2. Diabetic supplies such as lancets, glucose testing tablets and strips. Such supplies are payable as Durable Medical Equipment (DME) as outlined in the Subscriber Agreement.

3. Drugs which are entirely consumed at the time and place of prescribing.

4. Charges for the administration or injection of any medication.

5. Any type of therapeutic or prosthetic device, appliance, support or hypodermic syringe (other than disposable syringes to inject insulin), even though such device, appliance, support or syringe may require a prescription. Such items may be payable as Durable Medical Equipment (DME) as described in the Subscriber Agreement.

6. Drugs dispensed to an Enrollee while an inpatient in a facility such as a hospital or similar institution when such institution dispenses and bills for medications used during confinement.

7. Replacement of lost, stolen, broken or discarded medications.

8. Drugs labeled "Limited by Federal Law to Investigational Use"; experimental drugs; or FDA-approved medications in experimental or non-FDA approved dosage forms, or for non-approved or experimental indications unless use is a commonly accepted standard of care as indicated by the following official compendia: United States Pharmacopeia Dispensing Information or American Hospital Formulary Service Drug Information.

9. Medications dispensed prior to the Effective Date or after the termination date of an Enrollee.

10. Medications dispensed by a facility other than a licensed pharmacy.

11. Drugs used for the treatment of infertility.

12. Growth hormone regardless of intended use.

13. Medication prescribed for cosmetic purposes including, but not limited to:

    Tretinoin (Retin A) if used to treat wrinkled or photo-aged skin
    Tretinoin (Renova) regardless of intended use
    Anabolic steroids used to enhance physical appearance or athletic performance

14. Dietary supplements, medications or treatment used for appetite suppression or weight loss, and nutritional supplies (e.g., Sustacal, Ensure, and Meridia).

15. Smoking deterrents, nicotine replacement products, medication, aids, treatment or supplies for nicotine or to promote smoking reduction or cessation.

16. Injectable medications that are not typically self-administered by the Enrollee.

17. Any medication for treatment of sexual dysfunction or impotence, or to improve sexual performance or functioning, including, but not limited to: Muse, Caverject, Viagra, and Yohimbine, but with the exception of Viagra which is covered up to six pills per month.

Section V LIMITATIONS

1. Prescription quantity shall be limited to the amount ordered by the prescribing provider for a specified course of treatment. Quantity per Prescription Fill or Prescription Refill shall not exceed a 34-day supply except that items on the 100-Day Supply List may be dispensed in quantities up to a maximum of 100-day supply.

2. Initial quantity of an Outpatient Prescription Drug will be the lesser of that which is necessary to treat the episode/condition for which the Outpatient Prescription Drug was prescribed or a 34-day supply, whether purchased at a retail pharmacy or through mail order.

3. An Enrollee will be considered to have an adequate supply of medication from the previous dispensing date and will be not be eligible for benefits under this rider if an insufficient number of days have elapsed between fills as determined by UnitedHealthcare.

4. UnitedHealthcare reserves the right to limit the quantity dispensed per Prescription Fill and the frequency of Prescription Fills or Prescription Refills to a reasonable amount for a specified condition or episode. UnitedHealthcare reserves the right to limit quantities of medications dispensed to usual dosing frequency approved by FDA.

5. UnitedHealthcare reserves the right to restrict payment for Co-Marketed Drugs to the Outpatient Prescription Drug which is included in the UnitedHealthcare Formulary.

6. Subject to physician authorization, UnitedHealthcare reserves the right to require substitution of a therapeutically equivalent product when clinically appropriate.

UnitedHealthcare Plan of the River Valley, Inc.
SUPPLEMENTAL BENEFITS RIDER TO SUBSCRIBER AGREEMENT
UNDER GROUP HEALTH CONTRACT

CHIROPRACTIC CARE RIDER

This rider is subject to all provisions of the Subscriber Agreement not in conflict with the provisions of this rider. In the event of such a conflict, the provisions in this rider shall govern coverage for chiropractic benefits.

Benefits will be payable for Enrollees for chiropractic care provided by a Network Provider who is a licensed Doctor of Chiropractic (D.C.) and who has entered into an agreement with ACN Group, Inc. (ACN) to provide chiropractic services for UnitedHealthcare. Services are subject to preauthorization by ACN.

Benefits payable under this supplemental rider do not apply toward any Outpatient Rehabilitative Therapy limits as defined in Attachment D of the Subscriber Agreement. Benefits payable under this rider are not subject to Deductibles, and Copayments do not apply toward the Maximum Out-of-Pocket Expense as shown in Attachment D of the Subscriber Agreement.

The following services are covered by UnitedHealthcare subject to a $10 Copayment. The balance is paid at 100%.

Covered Chiropractic Services

- Diathermy
- Electric Stimulation
- Emergency Room
- Massage
- Medical Supplies
- Office Visits
- Diagnostic Evaluation and X-ray services for the purpose of diagnosing the appropriateness of chiropractic treatment
- Spinal Manipulation
- Traction
- Ultrasound

Services by Non-Network Provider

Services provided by a Non-Network Provider must be preauthorized by ACN and will be paid according to the above schedule. Services received from a Non-Network Provider resulting from self-referral are not covered under this supplemental rider.

Benefit Exclusions

The following services are not payable under this rider:

Acupressure • Acupuncture • Arch Supports • Biosoterometric Studies • Cervical Pillow • Chelation Therapy • Colonic Therapy or Irrigations • Computerized Axial Tomography • Durable Medical Equipment • Graphic X-ray Analysis • Hair Analysis • Hand Held Doppler • Heavy Metal Screening • Iridology • Iris Analysis • Kinesiology • Living Cell Analysis • Magnetic Resonance Imaging • Maintenance Care • Mineral Cellular Analysis • Moire Contourographic Analysis • Nutritional Counseling • Nutritional Supplements • Over-the-Counter Drugs or Preparations • Oxygen Therapy • Ream's Lab or Ream's Test • Rolfing • Sublingual or Oral Therapy • Thermographic Procedures • Toxic Metal Analysis.

UnitedHealthcare Plan of the River Valley, Inc.
SUPPLEMENTAL BENEFITS RIDER TO SUBSCRIBER AGREEMENT
UNDER GROUP HEALTH CONTRACT

VISION CARE RIDER

This rider is subject to all provisions of the Subscriber Agreement not in conflict with the provisions of this rider. In the event of such a conflict, the provisions in this rider shall govern coverage for vision care benefits.

Routine Vision Care

Benefits will be paid subject to the limitations and provisions hereinafter contained for charges made by an Opthalmologist, Optometrist, or Optician.

Copayments

$10 Copayment per examination.

Note: Copayments do not apply toward medical Maximum Out-of-Pocket Expense or Deductible.

Maximums

One examination once every 12 consecutive months.

Benefit Exclusions

1. Hardware (lenses, frames, eyeglass cases, and contacts).
2. Charges for which benefits are otherwise provided under this health benefit plan.
3. Procedures determined to be special or unusual, such as, but not limited to, orthoptics, vision training, subnormal vision aids, and aniseikonic lenses.
4. Safety glasses for use by an employee.
5. Charges for failed appointments.
6. Charges for replacement of broken lenses or frames.
7. Services rendered after the date the Enrollee ceases to be eligible for coverage.
8. Charges for services which are not necessary, or which do not meet accepted standards of ophthalmic practice, or which are experimental in nature.

Definitions

Opthalmologist	Any licensed physician of medicine or osteopathy legally qualified to practice medicine, within the scope of his or her licensed authority, including the diagnosis, treatment, and prescribing of lenses related to conditions of the eye.
Optician	Any person who makes or sells eyeglasses prescribed by an Ophthalmologist or Optometrist to cure or correct defects in the eyes, and grinds or has lenses ground according to the prescription.
Optometrist	Any person legally licensed to practice optometry as defined by the laws of the state in which the service is rendered.
Vision Examination	An examination of visual ability and acuity. It includes an external examination of the eye, refraction, binocular measure, ophthalmoscopic examination, tonometry when necessary, or recommendations including prescription for lenses when necessary. This examination must be performed by an Ophthalmologist or Optometrist.

Member Bill of Rights and Responsibilities

As a member of UnitedHealthcare Plan of the River Valley, you have certain rights and responsibilities, which are outlined below.

MEMBER BILL OF RIGHTS

Members have the right to:

- Be treated with respect and dignity by UnitedHealthcare personnel and network physicians and providers.
- Privacy and confidentiality for treatments, tests or procedures you receive.
- Voice concerns about the service and care you receive.
- To register complaints and appeals concerning your health plan or the care provided to you.
- Receive timely responses to your concerns.
- Participate in a candid discussion with your physician about appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Be provided with access to health care, physicians and other health care professionals.
- Participate with your physician and other caregivers in decision about your care.
- Make recommendations regarding the organization's member's rights and responsibilities policies.
- Receive information about UnitedHealthcare, our services and network physicians and other health care professionals.
- Be informed of, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards.
- Choose an Advance Directive to designate the kind of care you wish to receive should you be unable to express your wishes.

MEMBERS' RESPONSIBILITIES

Members are responsible for:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your ID card before receiving health care services.
- Pay any necessary copayment at the time you receive treatment.
- Use emergency room services only for injury or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow agreed-upon instructions and guidelines of physicians and health care professionals.
- Participate in understanding your health problems and developing mutually agreed upon treatment goals.
- Notify your employer's human resource department of changes in address or family status.
- Visit our Web site **www.uhcrivervalley.com**, or call customer service when you have a question about your eligibility, benefits, claims and more.

- Access our Web site **www.uhcrivervalley.com** or call customer service to verify that your physician or health care professional is participating in the UnitedHealthcare Plan of the River Valley network before receiving services.

Advance Medical Directives

UnitedHealthcare Plan of the River Valley, Inc. has been instructed by federal law to inform you about your rights under The Patient Self-Determination Act.

What happens if you become too sick to make your own decisions regarding your medical care? Your family and doctor must decide what treatment to use, when not to treat, and when to stop treatment. Sometimes they don't know what you would want, or aren't able to agree on what would be best for you. It is much better if they are sure of what you want and who you want to make these decisions.

With the enactment of a federal law, The Patient Self-Determination Act, you have the right to make decisions about your future health care. This includes the right to accept or refuse medical or surgical treatment and to plan and direct the types of health care you may receive if you become unable to express your wishes. You can exercise this right by making an Advance Medical Directive.

UnitedHealthcare Plan of the River Valley, Inc. supports your rights under this law. However, coverage of your medical care by UnitedHealthcare Plan of the River Valley, Inc. is in no way influenced by your having an Advance Medical Directive.

UnitedHealthcare Plan of the River Valley, Inc. participating providers have, in accordance with state law, varying practices regarding the implementation of an advance directive. Such practices must be made available to you when selecting or receiving care from the provider.

For example, if your physician, as a matter of conscience, is unable to comply with your directives, they must take all reasonable steps to arrange to transfer you to another physician.

What is an Advance Directive?

An advance directive explains, in writing, your choices about the treatment you want or do not want, or about how health care decisions will be made for you if you are too ill to express your wishes.

An advance directive expresses your personal wishes and is based upon your beliefs and values. When you make an advance directive, you will consider issues like dying, living as long as possible, being kept alive on machines, being independent, and the quality of your life.

Use of an Advance Medical Directive makes it possible for your wishes to be carried out during a serious illness.

If you are an adult and of "sound mind," you can make an advance directive.

There are two types of formal advance directives. You can complete either a Living Will, a Power of Attorney for Health Care, or both.

Living Will

A Living Will informs your physician that you want to die naturally if you develop an illness or injury that cannot be cured. It tells your physician that, when you are near death or in a vegetative state, he or she should not use life-prolonging measures which postpone, but do not prevent, death.

A Living Will allows you to refuse treatments or machines which keep your heart, lungs or kidneys functioning when they are unable to function on their own.

The Power of Attorney for Health Care

The Power of Attorney for Health Care is a form in which you appoint another person (a "health care agent") to make health care decisions for you if you are not capable of making them yourself.

Maintaining Your Advance Directive

You should keep your advance directive in a safe place where you and others can easily find it. (Do not keep it in a safe deposit box.) You should make sure your family members and your lawyer, if you have one, know you have made an advance directive and know where it is located. Be sure your Plan physician has a copy of your directive in your medical file.

Most states have specific rules as to what will be recognized as a valid advance directive. Forms are available through your state's Medical Society or Bar Association. Follow the instructions provided by your state when completing the advance directives forms.

Will All States Recognize My Directives?

If you plan to spend time in a state other than your state of residence, from which you obtained your Advance Medical Directives, you may wish to execute advance directives in compliance with that state's laws as well.

Specific questions should be directed to your physician and/or attorney for guidance.